MASSACHUSETTS

DEPARTMENT OF PUBLIC HEALTH

EARLY INTERVENTION

OPERATIONAL STANDARDS

REVISED 2006

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EARLY INTERVENTION SERVICES

OPERATIONAL STANDARDS

I. INTRODUCTION

The Massachusetts Department of Public Health (MDPH) is the designated lead agency for Part C of the Individuals with Disabilities Education Act of 2004. Operational Standards are developed based on Part C of Public Law 108-446 34 CFR Part 303 Early Intervention Program for Infants and Toddlers with Disabilities, and on Massachusetts General Law, Chapter 111G.

The Massachusetts Early Intervention system is comprised of community-based programs certified as Early Intervention providers by the Massachusetts Department of Public Health. Early Intervention in Massachusetts is a statewide, integrated, developmental service available to families of children between birth and three years of age. Children may be eligible for EI if they have developmental difficulties due to identified disabilities or delays, or if typical development is at risk due to certain birth or environmental circumstances

The Individualized Family Service Plan (IFSP) is developed in collaboration with families based on functional outcomes as determined by the family with respect to their concerns and priorities. Services and staff reflect the cultural, linguistic, and ethnic composition of the state and of families enrolled. Early Intervention services focus on the family unit, utilizing family resources and daily routines to enhance the child's growth and development. Early Intervention staff work in partnership with individuals present in the child's natural environment. Early Intervention staff support and encourage the family's use of and access to community-based resources that will continue to support and enhance the child's development.

These standards are developed to describe requirements of community Early Intervention programs and are used as criteria by the Massachusetts Department of Public Health for ongoing monitoring, for contract performance review and for Early Intervention program certification. These standards, and all Massachusetts DPH-certified Early Intervention programs, incorporate into their practice the following core values:

1. ***RESPECT***

Recognizing that each group of people has its own unique culture, and honoring the values and ways of each family's neighborhood, community, extended family, and individual unit.

2. ***INDIVIDUALIZATION***

Tailoring supports and services with each family to its own unique needs and circumstances.

3. ***FAMILY-CENTEREDNESS***

Basing decisions with each family on its own values, priorities, and routines.

4. ***COMMUNITY***

Realizing that each family exists in the context of a greater community, and fostering those communities as resources for supports and services.

5. ***TEAM COLLABORATION***

Working as equal partners with each family and with the people and service systems in a family's life.

6. ***LIFE-LONG LEARNING***

Viewing early intervention supports and services as a first step on a journey for each child, family, and provider.

II. DEFINITIONS

Caregiver As used in these standards, a caregiver is a person in whose care a child may be temporarily placed, including, but not limited to, non-custodial relatives, baby-sitters, child care providers, and nannies.

Child Find/Public Awareness Child Find is a series of activities in the community that provide public awareness regarding Early Intervention services.

Child-Focused Group Settings Child-focused groups may be provided in any of three types of settings: lead, shared or participatory, as defined in these standards. Each type of setting is subject to DPH approval, as defined in Section XI., E of these standards. Adult/child ratios for child-focused groups are as follows:

1) **Lead site**, where the Early Intervention program is responsible for enrolling children, planning curriculum, and ensuring that the physical facility meets the current Early Intervention Operational Standards criteria. Space can be owned, leased, rented, or borrowed.

a. Children under 18 months of age must be accompanied by a parent or caregiver (as defined in these standards) for any center-based activity at a lead site. Parents/caregivers must remain on site but are not required to remain in the group with the children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staff person (can include interns, volunteers, EI assistants, or EI associates) for every two children under 18 months. If only one EI staff person is present, it must be the EI Specialist who facilitates or co-facilitates the group.

b. Children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staff person for every three children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community children are expected to attend the

group then parents/caregivers of EI-enrolled children are also expected to attend. Attendance sheets must be maintained for all participants.

2) **Shared site**, where the Early Intervention program and a community program (MFN, YMCA, for example) both are responsible for enrolling children, planning curriculum, and ensuring that the physical facility meets the current EIOS criteria. Program policy and procedures may be written by the EIP or the community program.

a. EI-enrolled children under 18 months of age must be accompanied by a parent/caregiver for any center-based activity at a shared site. Parents/caregivers must remain on site but are not required to remain in the group with children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staff person for every two EI-enrolled children under 18 months.

b. EI-enrolled children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staff person for every three EI enrolled children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community children are expected to attend the group then parents/caregivers of EI-enrolled children are also expected to attend. Attendance sheets must be maintained for all participants.

3) **Participatory site**, where the Early Intervention program joins an already existing activity in the community (library story hour, art center activity hour, for example). The Early Intervention program is not responsible for planning curriculum or ensuring the physical facility meets the current EIOS criteria.

a. EI-enrolled children under 18 months of age must be accompanied by a parent/caregiver for any activity at a participatory site. Parents/caregivers must remain on site but are not required to remain in the group with children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staff person for every two EI-enrolled children under 18 months.

b. EI-enrolled children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staff person for every three EI-enrolled children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents of community children are expected to attend the group then parents of EI-enrolled children are also expected to attend. Documentation of attendance may be requested of the site staff, and filed in the children's files with progress notes.

Co-treatment visit A co-treatment visit is either a home visit or a center-based individual visit with two or more Early Intervention Specialists. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and implementation. One co-treatment visit is allowed per month for an enrolled child. Consultative visits with DPH-contracted specialty service providers for children with low incidence conditions are not considered co-treatments.

Day As used in these standards, day means calendar days.

Due Process Due Process refers to the policies and procedures established by the Massachusetts Department of Public Health to ensure the rights of families with children eligible for early intervention through procedural safeguards and options for the timely, impartial resolution of disputes.

Early Intervention Program An Early Intervention program is one that is certified by the Massachusetts Department of Public Health as a community Early Intervention program and is in compliance with these standards and with IDEA, 2004.

Early Intervention Services

General Early Intervention services are

(1) designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development;

(2) determined in collaboration with the family in accordance with the Individualized Family Service Plan; and

(3) provided by qualified personnel as defined by these standards.

Types of Services

Service limitations, i.e., frequency, duration, staffing, etc. are defined by the Department of Public Health.

(A) Home Visit A face-to-face meeting at the enrolled child's home or a setting outside of the Early Intervention program's primary (lead) site with at least the enrolled child, the enrolled child's parent, or both, and an Early Intervention Specialist for the purpose of furthering the child's developmental progress.

(B) Center Individual Visit A face-to-face meeting of the child, the child's primary caregiver or both, with qualified professional(s) in a segregated setting other than the child's home for the purpose of furthering the child's developmental progress.

(B-1) Center Individual Visit A one-to-one (professional to child and/or caregiver) visit provided at the EI site or at another service site or private clinic with whom the EIP has contracted to provide Early Intervention services. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting.

(B-2) Center Individual Visit A one-to-one (professional to child and/or caregiver) visit provided in conjunction with an **EI-only Child Group**, identified on the IFSP as a Center Individual Visit provided as part of an EI-only Child Group. This

service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting.

(B-3) Center Individual Visit A one-to-one (professional to child and/or caregiver) visit provided in conjunction with a community-based child group service **held at any DPH-approved site** and identified on the IFSP as a Center Individual Visit occurring within a Community Group setting. This service does not require clinical justification as it does not occur in a segregated setting.

(C) Child Focused Group A face-to-face meeting at a community-based site of a group of enrolled children (2 or more), facilitated or co-facilitated by at least one certified Early Intervention Specialist (as defined in these standards) for the purpose of furthering the enrolled child's developmental progress.

There are two types of Child Focused Groups: **(1) Community Child Group** and **(2) EI-Only Child Group**. Each type of group must follow the ratios outlined in the definition of Child Focused Group Settings.

Community Child Group A group of two or more children designed to provide developmental opportunities for children ages birth to three, including children who are participating in group services as part of an Individualized Family Service Plan, and children who are not enrolled in Early Intervention. The purpose of the group is to enhance each child's development, and to provide opportunities for young children to come together. The Community Child Group supports the concept that Early Intervention services are most effective when provided in families' everyday routines and activities.

Community Child Groups are provided in locations where young children are welcome and typically spend time. Everyday places may include childcare settings, playgrounds, libraries, community centers, Early Intervention programs, or other neighborhood and community programs. This Child Group should be specified on the IFSP as a "Community Child Group."

EI-Only Child Group A developmental group of two or more children where the only participants are children and families enrolled in EI. When a child participates in an EI-Only Child Group, the child's IFSP must include appropriate clinical justification as to why outcomes cannot be achieved in a natural setting, as well as a plan to move toward group services in a community setting. The justification and the plan need to be reviewed a minimum of every six months through the IFSP process. This Child Group should be specified on the IFSP as "EI-Only Child Group."

(D) Parent-Focused Group A face-to-face meeting of a group of enrolled children's **parents** with an Early Intervention Specialist for the purpose of support and guidance. A Parent-Focused Group(s) is provided for a regularly scheduled period of time. If more than one parent of a child attends a group, the reimbursement for one of the parents (or both if no other insurance coverage) may be from the Department of Public Health. Time-limited (one or more sessions), topic-specific parent educational groups may be provided as Parent-Focused Groups. These sessions are based on a specific curriculum and have an evaluation component, kept on file at the program.
A group for other members of the enrolled child's family, including siblings, may be offered for not more than twelve sessions in a twelve-month period. These sessions will be based on a specific curriculum that addresses the impact of the developmental needs of the enrolled child on family members.

(E) Intake The initial face-to-face contact with the family by the EI program to provide an opportunity for discussion with family members regarding potential participation in Early Intervention, leading to written informed consent for the eligibility evaluation and IFSP development as appropriate.

(E) Assessment The ongoing procedures used by appropriately qualified personnel throughout the child's eligibility to identify (1) the child's unique strengths and needs; and (2) the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

Eligibility evaluations (See definition below) may take place as part of an assessment. When evaluation and assessment take place simultaneously, both eligibility and the strengths and needs of the child are determined by a multidisciplinary team. This event is referred to as an eligibility evaluation and assessment.

Early Intervention Specialist An individual who meets the criteria specified in Section V., B of these standards and is certified by the Massachusetts Department of Public Health prior to working in a professional capacity within the EI system. The certification may be provisional, provisional with advanced standing, or full certification.

Eligible Children Children, birth to age three, living in Massachusetts, who through a multidisciplinary team evaluation by a certified Early Intervention program are deemed eligible to receive Early Intervention services. Eligible children may receive EI services up to but not on their third birthday.

Eligibility evaluation A face-to-face meeting with the child and the parent(s) for the purpose of determining a child's initial or continuing eligibility for Early Intervention services.

Functional Outcomes Functional Outcomes, identified on the IFSP, are based on the family's strengths, concerns and priorities, are developed to provide flexible services to enhance a child's performance in daily activities and relationships, and are determined by families based on what they would like to accomplish for their child and family while participating in Early Intervention. Outcomes are specific, can be measured and achieved. New outcomes can be generated at any time throughout the IFSP process.

Individualized Family Service Plan (IFSP) The written plan for providing Early Intervention services to an eligible child and the child's family in accordance with federal regulations and with the Massachusetts Department of Public Health Early Intervention Operational Standards.

Low-Incidence condition Low incidence refers to a diagnosis of blindness, vision loss (not corrected by medical intervention) deafness, hearing loss, deafblindness, autism spectrum disorder (Autism, Pervasive Developmental Disorder, Asperger Syndrome, Child Disintegrative Disorder, and Rett Syndrome).
A child who has any one of these conditions is eligible for Speciality Services from a professional or a team of professionals with appropriate training to address the particular needs of each of these conditions.

Multidisciplinary team A team consisting of two or more Early Intervention Specialists of different disciplines, as defined in Section V. of these standards.

Natural Settings Settings that are typical for children similar in age of all abilities.

Parent As used in these standards, parent means the birth or adoptive parent of the child, foster parent, guardian, other person with whom the child lives who is legally responsible for the child's welfare or a surrogate parent, but does not include any parent whose authority to make educational decisions has been terminated under state law.

Parent Contact A parent whose child is currently enrolled in an early intervention program. This parent volunteers to work with the Parent Leadership Project to receive information and share it with other families and staff in their early intervention program. The Parent Contact also shares program news and information regarding family involvement with the Parent Leadership Project. Parent Contacts are vital links in the information chain as the information is then shared with other families through the statewide newsletter, the *Parent Perspective*.

Parent Liaison A family member of a child who is currently receiving or who has received EI services and is employed by the EI program to foster family involvement in program activities and share the *Parent Perspective* newsletter with fellow staff members.

Parental Consent This term means that (1) the parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's primary language or other mode of communication; (2) the parent understands and agrees in writing to the carrying out of the activity for which consent is sought and the consent describes that activity and lists the records (if any) that will be released and to whom; and (3) the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

Primary Language The language or mode of communication typically used by the parent of a child seeking or using services. If the parent has a vision or hearing loss, the mode of communication shall be that typically used by the parent, such as sign language, Braille, oral communication or other appropriate mode of communication.

Procedural Safeguards The policies and procedures established to ensure providers inform families of their rights to written notice, use of native language, informed consent, records, confidentiality, and options for the impartial timely resolution of disputes associated with the provision of early intervention services.

Service Coordination As used in these standards, service coordination means the activities carried out by a service coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the state's Early Intervention system.

Specialty Provider A professional who is specifically trained and/or credentialed in working with children with low incidence conditions and their families.

Specialty Services Children with low incidence conditions may require specialized care and services that may not be appropriately, adequately, or specifically provided within the existing early intervention system. These Specialty Services are provided by a clinician with special skills or knowledge, who might be a teacher of the deaf, a teacher

of the visually impaired, a professional with expertise in autism, an assistive technology specialist, or a clinician with other skills appropriate to a particular child's needs.

Staff Liaison The Staff Liaison is the designated EI staff member who facilitates the involvement of a diverse and representative number of families and serves as a link between staff and families.

Strategies The specific activities that support the family's capacity to meet the desired outcomes throughout the child's typical daily routine.

Surrogate Parent A surrogate parent is an individual assigned by the Massachusetts Department of Public Health to represent the rights of an eligible child in the following circumstances: (1) when the Department, after reasonable efforts, is unable to identify or locate the parent, guardian or person acting as parent of the child; or (2) when the child is in the legal custody of a State agency and the natural parent's rights to participate in educational decision making have been terminated. In this case, a foster parent will be designated as surrogate unless he or she indicates or demonstrates an unwillingness or inability to serve as surrogate.

Timely Services Those services that begin within, and do not exceed, 30 days of the IFSP signature date. Early Intervention Programs are encouraged to make good faith efforts to begin services immediately following the day of the IFSP signature. Services designated by the IFSP team as "weekly" should begin within one week, and services designated as "monthly" should begin within one month.

Transition Planning Conference The required meeting that is held with a child and/or his/her family, and documented on the "Transition Page" of the IFSP, at least 90 days and up to 9 months prior to the child's third birthday. The purpose of the conference is to inform the family about all possible transition options and to prepare the family for the termination of EI services.
For children potentially eligible for service through their Local Education Agency (LEA), the LEA must be invited to the conference. The transition planning conference must

include a discussion of concrete next steps, and must be documented as a transition planning conference on a contact note.

Written informed consent A form or other written record which serves as evidence that the explanation required for informed consent has been provided. The parent's signature shall serve as documentation that the parent understands and agrees to the proposed terms and activities.

III. Eligibility for Early Intervention Services

A. Determination of Eligibility

Massachusetts Department of Public Health Certified Early Intervention programs determine eligibility through an evaluation conducted by a multidisciplinary team based on informed clinical opinion and utilizing a DPH-approved developmental inventory tool. Instruments approved by the Department of Public Health for establishing eligibility, as of 7/1/05, are: the Early Intervention Developmental Profile ("Michigan") and the Battelle Developmental Inventory - 2 ("BDI-2").

B. Categories and Criteria of Eligibility

1. Children with Established Risk or Established Developmental Delays : This category includes (1) children whose early development is influenced by diagnosed medical conditions of known etiology bearing relatively well known expectations for developmental delay and (2) children who, during the infancy period, or more commonly in the second year of life, begin to manifest developmental delays, often of unknown etiology.

Criteria

(1) The child has:

- A diagnosed neurological, metabolic, or genetic disorder, chromosomal anomaly, medical or other disabling condition with documented expectation of developmental delay, **or**
- vision loss not corrected by medical intervention or prosthesis, **or**
- permanent hearing loss of any degree, **or**

(2) The child exhibits a delay of 25% or more, as measured by an approved instrument yielding age equivalent scores, in one or more areas of development, including: physical development (includes gross and fine motor), cognitive development, communication development (includes expressive or receptive), social or emotional development, or adaptive development, **or**

(3) The child's development is at least one standard deviation below the norm, as measured by an approved instrument yielding standard deviation scores, in one or more areas of development, including: physical development (includes gross and fine motor), cognitive development, communication development (includes expressive or receptive), social or emotional development, or adaptive development, **or**

(4) The child has questionable quality of developmental skills and functioning based on the informed clinical opinion of a multidisciplinary team. A child found to be eligible based on the category of "clinical judgment" can receive services for up to 6 months. For services to continue after this period, eligibility must be determined based on diagnosis, developmental delay or risk factors.

2. Children at Risk for Developmental Delays or Disorders: This category includes:

(1) children with a history of prenatal, perinatal, neonatal, or early life events suggestive of biological insults to the developing central nervous system which, either singularly or collectively, increase the probability of later atypical development and (2) children who are biologically sound but whose early life experience, including maternal and family care, health care, nutrition, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are sufficiently limiting to the extent that they impart high probability for delayed development.

Criteria:

Four or more of the following risk factors are present:

CHILD CHARACTERISTICS

Note 1: Risk factors 1 – 4 apply only to children who are under 18 months chronological age at the time of the evaluation for eligibility.

Note 2: Birth or medical records are available to substantiate risk factors 1 – 8.

1) Birthweight is **less** than 1200 grams (2 pounds 10½ ounces)
2) Gestational age is **less** than 32 *weeks Developmental evaluation for eligibility will be based on chronological age, not on adjusted age.*
3) NICU admission is **more** than 5 days
4) Apgar score is **less** than 5 @ 5 minutes
5) Total hospital stay is **more** than 25 days in 6 months *This does **not** apply to the birth admission of a premature child. Subsequent admissions to a hospital or the transfer hospital stay after NICU admission will apply toward this total.*

6) Diagnosis of Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA)

7) Weight for age, or weight for height *A child meets this risk criterion if weight for age or weight for height is less than the 5th percentile or greater than the 95th percentile.* Weight for age has **dropped** more than 2 major centiles in 3 months in a child who is under 12 months of age or has dropped more than 2 major centiles in 6 months in a child who is 12 to 36 months of age. *A major centile is defined as the major percentiles (5, 10, 25, 50, 75, 90, 95) on the Physical Growth Chart adopted by the National Center for Health Statistics. The above two measurements should be based on the appropriate growth chart approved by the National Center for Health Statistics.*

8) Blood lead levels measured at 15 µg/dl (micrograms per deciliter) or more. *A child meets this risk criterion with a **venous** (not finger stick) blood lead level of 15 µg/dl (micrograms per deciliter) or more.*
9) Chronic feeding difficulties *A child meets this risk criterion if any of the following conditions exist over an extended period of time:*
    - *Severe colic*

- *Stressful or extremely conflicted feedings*
- *Refusal or inability to eat*
- *Failure to progress in feeding skills*

Evidence of this criteria should be documented in the child's record and appropriate outcomes and treatment strategies addressed as determined by the family. Note: If a child has been <u>diagnosed</u> as failure-to-thrive, the child is eligible under established risk.

10) Insecure attachment/interactional difficulties *A child meets this risk criterion if the child appears to have **inadequate or disturbed social relationships, depression, or indiscriminate aggressive behavior** <u>and</u> **the family perceives this as an issue.** Note: In most cases, insecure attachment in infants and toddlers is evidenced by behavior such as persistent failure to initiate or respond to social interactions, fearfulness that does not respond to comforting by caregivers, and indiscriminate sociability. The child's family must perceive this as an issue for it to be included as a risk criterion.*

11) Suspected Central Nervous System abnormality -- *<u>Suspected</u> CNS abnormalities may include but are not limited to the following:*

- *Infection: meningitis, encephalitis, maternal infection during pregnancy (TORCH infections – toxoplasmosis, other (syphilis and HIV), rubella, CMV, herpes).*
- *Trauma: intracranial hemorrhage, subdural hematoma, epidural hematoma.*
- *Metabolic: Profound and persistent hypoglycemia, seizures associated with electrolyte imbalance, profound and persistent neonatal hyperbilirubinemia (greater than 20 mg/dl [milligrams per deciliter], acidosis.*
- *Asphyxia: prolonged or recurring apnea, ALTE [apparent life threatening event], suffocation, hypoxia, meconium aspiration, near-drowning*
- *In utero drug exposure: nicotine, ethanol, THC, cocaine, amphetamine, phenytoin, barbiturates and other.*

This category may also include the following clinical findings:

- *Abnormal muscle tone*
- *Persistence of multiple signs of less than optimal sensory and motor patterns, including under-reaction or over-reaction to auditory, visual, or tactile input.*

12) Multiple trauma or losses *A child meets this risk criterion if he/she has experienced a series of traumas or extreme losses that may impact on the care and/or development of the child. For example, multiple hospitalizations or multiple placements outside the home. This risk factor should be documented in the child's record and appropriate outcomes and treatment strategies addressed as determined by the family.*

FAMILY CHARACTERISTICS

NOTE #1 – Regarding children in the care of someone other than the child's birth/ natural parent: If the DSS (Department of Social Services) goal is for the reunification of the parent and child, the following risk factors apply based on the birth/natural parent. The EI program should work closely with both the birth/natural and foster families of the child, whenever possible. If there is no goal for reunification with the child's birth/natural parents, the family risk factors are to be based on the family characteristics of the primary caregivers.

NOTE #2 – Determination of risk factors under family characteristics should be determined by family perception.

NOTE #3 – Maternal characteristics apply as risk factors to fathers if the father is the primary caregiver.

1. Maternal age at child's birth is **less** than 17 years or there is a maternal history of 3 or more births before age 20.

2. Maternal education is less than or equal to 10 years *A mother meets this risk criterion if she has completed 10 years or less of formal education at the time of the eligibility evaluation.*

3. Parental chronic illness or disability affecting caregiving ability *A family meets this risk criterion if one parent has a diagnosed chronic illness or a sensory, mental, or developmental disability which is likely to interfere with or adversely affect the child's development or have an impact on care-giving abilities. Examples of this risk factor may be affective disorders, schizophrenia, sensory limitations, including visual or hearing limitations, and cognitive limitations.*

NOTE #4 – The following risk factors should be documented in the child's record and appropriate outcomes and strategies addressed as determined by the family.

4. Family lacking social supports *A family meets this risk criterion if the family is geographically or socially isolated and in need of emotional support and services.*

5. Inadequate food, clothing or shelter, including homelessness *A family meets this risk criterion if the lack of food, clothing, or a stable housing arrangement cause life stress for the family.*

6. Open or confirmed protective service investigation, including child currently in foster care *A family meets this risk criterion if the family:*
    - *has an open protective service file with the Department of Social Services, or*
    - *is in the period of investigation for child abuse or neglect, or*
    - *has had its file closed by DSS in the last 3 months*

7. Substance abuse in the home *A family meets this criterion if substance abuse is having or may have an adverse affect on the child's development.*

8. Domestic violence in the home. *A family meets this risk criterion if domestic violence is having or may have an adverse affect on the child's emotional development. This category may include physical, sexual, or emotional abuse.*

IV. Catchment Area

A. Local Catchment Area

An Early Intervention program serves all cities and towns within its catchment area as approved by the Department of Public Health. If more than one EI program shares a catchment area or a family is referred to an EI program outside the catchment area of the family's residence, upon referral to a program, parents are notified of the names of the other programs serving that catchment area and have the opportunity to talk with the other programs before having an eligibility evaluation. At the initial visit each family will be provided information about the *Massachusetts Early Intervention Program Guide* which contains the statewide listings of all Early Intervention programs.

B. Options

Parents are made aware that they may only enroll in one Early Intervention program. Once the family makes the choice, the program has 45 days to evaluate the child, determine eligibility and hold a meeting to discuss the Individualized Family Service Plan (IFSP). Parents are also informed that investigating other programs may prolong the time it takes to complete the IFSP process. This discussion is documented in the intake file.

C. Out of Catchment Services

Programs are responsible for providing individualized services to families as outlined in the IFSP. Occasionally this means that services may be provided outside of the catchment area in which the family resides.

The DPH Regional Early Intervention Specialist must be notified in writing of families not residing in the program's catchment area being served by the program.

V. Service Providers and Roles

A. Professional Certification

All professional staff members who will be providing direct service to children and families, employed directly or indirectly by an Early Intervention program (including salaried, contract/fee for services, or consultant/subcontract), are certified as Early Intervention Specialists by the Massachusetts Department of Public Health prior to billing for Early Intervention services.

All staff new to the field of early intervention in Massachusetts, who work 20 hours or more per week in a Massachusetts EI program, are required to attend and participate in a two-day orientation training offered by the Department of Public Health's Training Center vendor. It is recommended that all new staff to the Massachusetts system participate in this training, completing both days by the end of their first year of employment.

Primary program administrators, usually Program Director or Program Coordinator, meet the credentialing requirements for one of the disciplines listed in Section B below. The primary program administrator is required to apply for Early Intervention Program Director certification within three years of hire to that position. Further description may be found in Section XII, Program Administration, of these standards.

Certification for Early Intervention Specialists:

a. Provisional certification is granted through the Department of Public Health to staff who meet entry level requirements and work in EI.
b. Provisional certification with advanced standing (PCAS) is granted through the Department of Public Health to graduates of DPH-approved higher education programs in early intervention after satisfactory review of completed application and transcripts. Application for full certification must be completed within 3 three years from the date the PCAS is issued.
c. Full certification is granted through the Department of Public Health after satisfactory completion of the EI certification process. Application must be

completed by the end of 3 years of employment for those working 20 hours or more per week at one or more MDPH-certified EI program(s). Those working fewer than 20 hours per week are also encouraged to apply for full certification.

The following are the requirements for full certification as a certified Early Intervention Specialist:

1. For staff with provisional certification:
    a. submission of a portfolio documenting competencies as an Early Intervention Specialist within three years of employment in an MDPH certified Early Intervention program.
    b. confirmation of at least 1440 hours of employment, working at least 20 hours per week.
2. For staff with provisional certification with advanced standing:
    a. completion of 1440 hours of supervised employment in a MDPH-certified early intervention program.
    b. Submission of the appropriate application for full certification.

B. Early Intervention Credentials

MDPH-certified EI programs must demonstrate a commitment to respond to the diversity of families in their communities. Staff should, to the extent possible, reflect the cultural, ethnic and linguistic background of families served. The following are the minimum credentials for entry level provisional certification as an Early Intervention Specialist:

1. *As Developmental Specialist:*
    a) A bachelor's degree from an accredited institution with a major or concentration in infants and toddlers (includes early intervention and early childhood education), and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    b) A bachelor's degree from an accredited institution with a major or concentration in child development or child studies, and at least 300

hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

c) A bachelor's degree from an accredited institution with a major or concentration in education or special education, and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

d) A bachelor's degree from an accredited institution, with at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

For a, b, c, and d transcripts of degree work or subsequent transcripts must reflect successful completion of at least 4 approved three-credit courses that focus on infants, toddlers, and families.

2. *In Nursing:* Current licensure as a Registered Nurse by the Massachusetts Board of Registration, Division of Professional Licensure.
3. *In Occupational Therapy*: Current licensure as an Occupational Therapist by the Massachusetts Board of Registration of Allied Health Professions.
4. *In Physical Therapy*: Current licensure as a Physical Therapist by the Massachusetts Board of Registration of Allied Health Professions.
5. *In Social Work*: Current licensure as a Licensed Clinical Social Worker (LCSW) or as a Licensed Independent Clinical Social Worker (LICSW) by the Massachusetts Registry of Social Work.
6. *In Psychology:* A master's degree from an accredited institution in
   (a) counseling psychology
   (b) clinical psychology
   (c) developmental psychology
   (d) educational psychology

   or

(e) Current licensure as a Licensed Mental Health Counselor (LMHC) by the Massachusetts Board of Allied Mental Health and Human Services Professions.

(f) Current licensure as a Licensed Marriage and Family Therapist (LMFT) by the Massachusetts Board of Allied Mental Health and Human Services Professions.

7. *In Speech and Language Pathology:* (a) Current licensure by the Massachusetts Board of Registration in Speech-Language Pathology and a Certificate of Clinical Competence (CCC) granted by the American Speech, Language and Hearing Association or (b) currently in clinical fellowship prior to being granted a CCC.

8. ***Specialty Provider***: Early Intervention services may also be provided by qualified personnel who bring specific expertise necessary for working with populations including, but not limited to, children with low incidence conditions and their families. A Specialty Provider may be granted limited provisional certification as an Early Intervention Specialist that does not include the capacity to function as a Service Coordinator. Qualification is based on applicable state requirements for the profession or discipline in which the person is providing early intervention services

C. Additional Credentials:

1. Early Intervention Assistant

Early Intervention Assistant is an entry-level position with an educational requirement of a high school diploma or equivalent. The duties of these individuals are generally

(1) organizational in nature, e.g. purchase of materials or coordination of transportation;

(2) related to child-focused groups, such as classroom preparation and/or

(3) supervised participation in activities with children and families.

2. Early Intervention Associate

The Early Intervention Associate has a minimum educational requirement of a high school diploma or equivalent with additional credentialing working with infants and toddlers. An EI Associate may have any of the following credentials:

(1) Completion of an associate degree in Early Childhood Education

(2) Credentialing as a Child Development Associate

(3) Registration and licensure in Massachusetts as a Certified Occupational Therapy Assistant or a Physical Therapy Assistant

(4) Designation as a Lead Infant/Toddler Teacher by the Massachusetts Department of Early Education and Care.

(5) Licensure in Massachusetts as a Licensed Practical Nurse

(6) Parent of a child enrolled for at least one year in a DPH-certified Early Intervention program

The scope of participation of an Early Intervention Associate includes work with children and families, under close and regular supervision and in accordance with the appropriate guidelines of practice for specific disciplines. Duties may include direct services to a child and family, participation in IFSP development, service coordination, program outreach, and intakes, all under the supervision of an Early Intervention Specialist.

Early Intervention Assistants and Early Intervention Associates do not bill for Early Intervention services.

VI. Entry Into Program

A. Referral

1. EI programs accept referrals from all sources. If the family is not the referral source, they should be informed prior to referral. If the family has not been informed, the EI program will encourage the referral source to inform the family. A face-to-face or telephone response to the family from the EI program is made within 10 working days following the initial referral. Attempts to contact families are documented in the child's record.
2. The EI program schedules a visit with the family preceded by written notification of what the visit will involve.
3. Once the visit has been scheduled, the EI program shall assign a contact person to be available to the family during the eligibility determination and IFSP process. Within 45 days after receiving a referral, the Early Intervention program will complete the evaluation and assessment activities and, if the child is found eligible for Early Intervention services, convene an IFSP meeting.

B. Intake

1. The initial face-to-face contact with the family provides an opportunity for discussion with family members regarding potential participation in Early Intervention. The visit is scheduled in response to family need with regard to time and location. Written parental consent is obtained in order for the visit to proceed. Often the child's medical and developmental histories are discussed and an overview of Early Intervention is given to the family. The family is informed of their right to a full assessment. Plans are made for the eligibility evaluation and assessment process.
2. The parent is given the Massachusetts Department of Public Health Notice of Family Rights. The program will make an effort to ensure that the parent understands the notice and that the parent has been given the opportunity to discuss the contents of the notice and to have questions answered. There is written evidence, including parent signature, that these requirements have been met.

C. Eligibility Evaluation

1. Eligibility evaluations are performed by certified Early Intervention programs.

2. Prior written notice and written parental consent is obtained prior to an eligibility evaluation.

3. A review of available records related to the child's current health status and medical history is to be completed as part of the assessment.

4. As a part of this process, an evaluation of the child's development is to be made by a multidisciplinary team using a DPH-approved developmental evaluation tool. Functioning in each of the following areas is evaluated to determine eligibility:

   a. Cognitive development

   b. Physical development (gross and fine motor), including vision, hearing, and health status

   c. Communication development, including expressive and receptive language development

   d. Social and emotional and personal development

   e. Adaptive development/self help

5. Eligibility evaluation further consists of a determination of family and child risk factors to document eligibility as described in Section III B.2. of these standards. An assessment of family resources, priorities, and concerns is family-directed and designed to determine ways to enhance the development of the child. Any assessment of a family's need for support or services is voluntary in nature, and based on information provided by the family through personal interviews conducted by personnel trained in appropriate methods and procedures. If the family chooses not to share this information they must be informed that their decision may impact eligibility.

6. The eligibility evaluation process is culturally and linguistically appropriate for the child and family.

7. The disciplines represented on the multidisciplinary evaluation team are determined, to the extent possible, by the developmental areas of concern for the child.

8. With written family consent, the primary referral source is notified in writing of the outcome of the eligibility evaluation.

D. Assessment

1. Assessment consists of those on-going procedures used by appropriately qualified personnel throughout the period of a child's eligibility for services to identify (1) the child's unique strengths and needs and the services appropriate to meet those needs; and (2) the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child.

2. The assessment emphasizes the collaborative process among Early Intervention personnel, the family, and other agencies and providers. Logistics should be primarily responsive to family and child needs and preferences regarding time, place and other such factors. Families will be given prior written notice of assessments which includes the voluntary nature of consent. Written informed parental consent is obtained prior to assessment.

VII. Individualized Family Service Plan Development

A. An Individualized Family Service Plan (IFSP) is a working document produced collaboratively by program staff and family members that contains the agreed upon Early Intervention services for an eligible child and family. Based on a multidisciplinary eligibility evaluation and any completed assessments, the plan includes services necessary to enhance the development of an eligible child, and the capacity of the family to meet the child's needs. All certified Early Intervention programs use the current universal IFSP form approved by the Massachusetts Department of Public Health.

B. An IFSP meeting is held with eligible families within forty-five days of referral. An IFSP meeting is convened at a time and place mutually convenient for the family and team members for the purpose of developing the plan. The Department of Public Health strongly discourages the practice of intake, eligibility evaluation and IFSP development on the same day. Prior written notice of the IFSP meeting is provided early enough to ensure attendance. Each initial and subsequent IFSP meeting, following an eligibility evaluation, includes the following participants:

1. The parent or parents of the child (or person legally designated in this function).
2. The individual designated to be the service coordinator.
3. Another person or persons directly involved in conducting the eligibility evaluation and assessment.
4. Other family or team members as requested by the parent if feasible to do so. *
5. An advocate or other non-family member, if the parent requests that the person participate. *
6. As appropriate, persons who will be providing services to the child and/or family.

* If a person the parent wishes to have involved in the planning meeting is unable to attend, arrangements are made for the person's involvement through other means, including:

1. Participating in a telephone conference call
2. Having a knowledgeable designate attend the meeting
3. Making pertinent records available at the meeting

C. The contents of the IFSP are fully explained to the child's family and informed written consent from the parents is obtained prior to the provision of Early Intervention services described in the plan. If the parents do not provide consent with respect to a particular EI service or withdraw consent after first providing it, that service may not be provided. ***This action will not jeopardize the provision of other Early Intervention services.*** The EI services to which parental consent is obtained must be provided.

D. The plan is written in the family's primary or chosen language, unless it is clearly not feasible to do so. An English translation of the child's developmental profile and the service delivery plan is available at the program site for coordination and program monitoring purposes.

E. The plan is based on the results of a multidisciplinary eligibility evaluation and includes the following:

1. A statement of the child's present level of cognitive development, physical development (gross and fine motor), (including vision, hearing, and health status), communication development, including expressive and receptive language development, social and emotional and personal development, and self-help/adaptive development.
2. A statement of the child's strengths and needs, including documentation of the techniques used to determine the strengths and needs.
3. A statement of the family's strengths, concerns, priorities and resources related to enhancing the development of the child, if the family so desires.

4. A statement of functional outcomes identified by the family expected to be achieved for the child and family. The team, which includes the family, identifies the strategies to be focused on, incorporating them into the child's and family's daily routines/activities. These strategies include the criteria, procedures and timelines used to determine (1) the degree to which progress toward achieving the outcomes is being made; and (2) whether modifications or revisions of the outcomes or services are necessary.
5. A statement of the Early Intervention services necessary to meet the unique needs of the child and family to achieve the functional outcomes, including transportation plans, service frequency (how often), duration (how long), and the location (where occurring) of sessions; whether these are individual or group services (method), and the EI staff member(s) (names and disciplines) responsible.
6. A statement of the natural settings in which Early Intervention will be provided, including justification of the extent to which the services will not be provided in a natural environment.
7. A statement of medical services, specialty providers and other community resources and services which are or will be involved with the child and family, with parental consent, including the Early Intervention program's plan for coordination with these resources.
8. The time period covered by the plan, including the projected date of initiation of services as soon as possible after the IFSP meeting. (See definition of Timely Services, Section II of these standards). Parents are kept informed of all efforts to secure services and documentation should reflect the search for services and methods used to obtain them. The date of parental signature shall constitute the initiation of the plan, with an expiration date not more than one year from initial parental signature.
9. The plan for service coordination agreed upon with the family, including the individual responsible for ensuring the coordination and implementation of the IFSP. This individual should be from the profession and/or have clinical experience most relevant to the child's or family's needs.

10. A statement of transition activities that include the following 5 points of transition:
    I. A review of options for the family
    II. Information for the family regarding the process of transition
    III. Support available to parents
    IV. Information to be sent to the Local Education Agency (LEA) and/or other community providers
    V. Specific plan for how the child will successfully transition to the next setting
11. At least six months before anticipated discharge, the plan for transition to services provided by the Local Education Agency (LEA) or to other appropriate settings. This process follows the steps outlined in the Interagency Policy on Early Childhood Transitions. See Appendix A of these standards.

    The IFSP must identify medical and other community services and resources that the child needs but that are not required under Part C of IDEA (Individuals with Disabilities Education Act) or M.G.L. 111G. The IFSP should also identify the steps that will be undertaken to secure those services through public or private resources.

F. At least every six months or whenever the family or another IFSP team member requests, the IFSP is reviewed by family and other team members. This review is to take place in a meeting or other means acceptable to the family and other participants. The review includes a determination of the degree to which progress is being made toward achieving agreed upon functional outcomes, appropriateness of services being delivered and/or possible changes in outcomes or service plan. These are documented on the corresponding pages of the IFSP.

G. Modifications in writing of the IFSP may occur at any time with written parental consent. Modifications may include changes in:
    - functional outcomes
    - specific Early Intervention services

- service frequency or location.
- information the parent chooses to have amended for any reason

The addition of new outcomes that do not affect specific services as noted on the IFSP Service Delivery Plan do not require consent from the family as noted on a Review Page. However, a copy of the new Outcomes Page should be given to the family. It is best practice to have a Review Page to document the discussion with the family that new outcomes have been decided on.

If an outcome is met or changed, a corresponding Review Page to show that the family agrees and consents to the change must be reflected on the Review Page and on the Outcomes and Strategies Page of the IFSP.

H. At least annually, a multidisciplinary eligibility evaluation is performed and a meeting is held to revise the IFSP as appropriate, based on eligibility evaluation results.

I. Parents must be provided with a copy of their family's IFSP, including each revision.

VIII. Early Intervention Services

A. Children and families receive individualized services, in accordance with the functional outcomes identified in the IFSP. A range of options, including home visits, center-based individual visits, community child groups, EI-only child groups (These child groups may include parents), parent groups and services of specialty providers is available to all families. Intervention is designed to include the child, staff member(s) and parent or designated caregiver. The parent is encouraged to participate in services. If family circumstances preclude such participation, this is documented in the child's record and alternative communication strategies developed.

B. Services are available on a twelve-month basis. Any scheduled interruptions of any IFSP service for more than three (3) consecutive weeks are discussed and approved by the family, and documented on the appropriate pages of the Individualized Family Service Plan. (Please refer to the definition of Timely Services, Section II of these standards regarding the designation of services.) Varying family needs and cultural differences are respected in the provision of Early Intervention services, and programs are responsive to family schedules.

C. Services are provided in the natural settings for the child, as determined through the IFSP process. Natural settings may include the child's home, childcare centers, family childcare homes, and other community settings.

D. The service coordinator is determined during the IFSP process. Functions of the service coordinator include the following:

1. Identify and negotiate service coordination functions with the family
2. Explain the IFSP process including due process and procedural safeguards
3. Facilitate and participate in the development, review and evaluation of the IFSP

4. Collaborate with the family in identifying their strengths, concerns, priorities and resources
5. Facilitate the timely delivery of services
6. Coordinate and monitor eligibility evaluations, ongoing assessments by qualified personnel, and service delivery
7. Provide information on parenting and community resources
8. Educate and/or support the family in advocating for their rights and needs
9. Inform the family of the availability of advocacy services
10. Coordinate services with medical and health providers, with written parental consent
11. Provide information and make referrals to other case management systems as appropriate and with written parental consent
12. Facilitate the development of a transition plan
13. Make recommendations and referrals to meet the individual needs of the child and family as appropriate and with written parental consent.

IX. Transition and Discharge

A. The program will discharge a child and family from Early Intervention services when:

1. The child reaches his or her third birthday
2. The child and family no longer meet eligibility criteria
3. The family withdraws consent for all services. This is documented in the child's record.
4. The program is unable to contact/locate the child and family after reasonable attempts to contact and after a written notice has been sent to the family. This is documented in the child's record.
5. The child dies. The program may provide support to the family during the initial grieving process, with a waiver from the Department of Public Health.

B. The discharge date of all children is on or before the child's third birthday. Eligible children may receive services up to but not on their third birthday.

C. Transition Plans that include the 5 points of transition must be developed for all children. Transition is the process by which a child and family are assisted in preparing for discharge from Early Intervention services. All information shared outside of the team requires written parental consent. Transition plans are developed:

1. When the family moves from one Early Intervention program to another. Staff from the sending program and the family determine the steps to be taken to facilitate a smooth transition, and the individual(s) responsible for each task. Staff from the receiving program and the family will convene an IFSP meeting within 45 days of the family's referral to review and update the existing IFSP. Disruptions of Early Intervention services to the child and family must be minimized, as much as possible.

2. For those children being referred to the Local Education Agency (LEA), a referral with written parental consent must be made at least six months before the child's 3rd birthday in accordance with MA Special Education Regulations (603 CMR 28.00, section 28.04 (1) (d). The Interagency Policy on Early Childhood Transitions (found in Appendix A of these standards) includes guidance for the planning process which will take place when the child is transitioning to special education services. At least 90 days before and up to 9 months prior to the child's 3rd birthday, with written parental consent, the Early Intervention program convenes a Transition Planning Conference with the family, a representative from the LEA and the Early Intervention program staff. The purpose of this meeting is to review the child's service history, discuss possible program options with the LEA, and establish transition activities. With written parental consent, information about the child, including evaluation and assessment information and relevant information from the IFSP is sent to the LEA.
3. When a child is determined ineligible for or has not been referred to preschool services under MA Special Education Regulations and is being referred elsewhere. With written parental consent, the EI program makes reasonable efforts to convene a Transition Planning Conference that includes the family and providers of other appropriate services for children (e.g., child care, Head Start, MA Family Networks, Community Partnerships for Children) to discuss appropriate services for which the child may be eligible.
4. When the child is under three years of age and either no longer meets the eligibility criteria for Early Intervention or the family chooses to terminate EI services. The reason for transition must be clearly documented in the child's record. Transition plans for children who are no longer eligible for EI services are in effect for up to forty-five days following the determination of ineligibility, at which time the child is discharged from the EI program. There is documentation in the child's record of mutual agreement of determination of ineligibility.
5. Transition plans are developed for children whose families choose not to move on to next step services after discussion of options.

X. Family Participation

A. Early Intervention in Massachusetts is a family-centered system. EI services are provided in a collaborative manner with families and EI service providers working as partners. Family members are encouraged to be active participants in every component of the Early Intervention service system. On an individual level family members are involved in determining and participating in services for their child and family. On the program level, families are encouraged to advise and participate in the development and monitoring of policies, procedures and practices. Family members may choose to participate in these advisory functions as a group or as individuals.

B. To ensure comprehensive family participation, all members of the EI service team share responsibility for providing an environment in which such participation can occur. Early Intervention programs provide multiple and varied opportunities for family participation that ensure responsiveness to the diverse needs and interests of the families in the service population and enhance the collaborative nature of service delivery.

C. In order to support family participation throughout the Early Intervention system, a program shall be able to demonstrate its efforts in the following activities:

1. Ensure that families understand the core values (see Section I of these standards) and range of individualized options, service delivery and supports.
2. Establish a mechanism to share information about services, supports and opportunities with all families on a regular basis, not only on the first visit.
3. Develop ongoing mechanisms that seek input from a diverse and representative number of families and incorporate the mechanisms into its policy and procedure/operations manual as part of its administrative organizational plan.

4. Ensure that all families are aware of the existence of and have access to the program's policy/procedure/operations manual. The program will assume the cost of copying specific policies on request.
5. Ensure that a diverse and representative number of families are invited to participate in the program's annual evaluation which should include areas such as:
    a. Feedback on staff performance
    b. Evaluation of program services
    c. Review of the IFSP process
    d. Options of family participation
    e. Review of transition procedures
6. Respond to written suggestions and evaluations offered by families within 7 days. Families who have difficulty in producing written documentation may request assistance.
7. Families and program staff will work together to develop an action plan to address concerns.
8. Include a diverse and representative number of families in any ongoing program development initiatives, such as the development of goals and objectives for the annual plan, service delivery task groups, modifications/updates to the policies and procedures, etc.
9. Develop mechanisms to share information about the EI statewide system and opportunities for family participation including but not limited to the following:
    - make the Parent Leadership Project website available to families (www.eiplp.org)
    - distribute *Parent Perspective* newsletter
    - invite a parent to accompany EI staff to an ICC (Interagency Coordinating Council) related activity
    - sponsor a parent to attend the MEIC (Massachusetts Early Intervention Consortium) Conference
    - inform families of statewide trainings

- encourage family participation on working committees

D. To assist in the above efforts, the program shall:

1. Designate a Staff Liaison (an EI staff member) to facilitate the involvement of a diverse and representative number of families and serve as a link between the staff and families
2. Invite and support a parent currently receiving EI services to be the contact person for the EI Parent Leadership Project; this parent contact will share information with the Parent Leadership Project and may also share information with program staff and families enrolled in the program.
3. Notify the Parent Leadership Project of the names of both the designated EI staff member and the current parent contact by calling 1-877-35-EI-PLP.
4. Invite a Parent Leadership Project Coordinator Team Member to attend at least one EI staff meeting annually.
5. Cover reasonable administrative expenses such as copying and distribution of information requested by families

E. Family Involvement Activities

1. Family members enrolled in Early Intervention programs may choose to participate in a variety of family involvement activities or join together in a formal group, called a PAC (Parent Advisory Council), in order to meet the diverse needs and interests of families in the program.

The program will ensure that families are informed that they have the option to form a PAC if one is not already established. Information and support is available to programs and families through the Parent Leadership Project (PLP).

2. The program has the responsibility to support a PAC or other family involvement activities by:

a. Ensuring information regarding activities is communicated to all enrolled families

b. Encouraging activities that are responsive to the cultural and linguistic diversity of the program

c. Designating an EI staff member who will be a link between the staff and the PAC

d. Covering reasonable administrative expenses

e. Copying and postage distribution expenses for family involvement activities or a PAC newsletter, if published

f. Assisting family members to problem solve solutions to overcome barriers to family involvement

g. Assisting with the management of funds raised

XI. Health and Safety

The following Health and Safety standards are based on the Health and Safety regulations of the Department of Early Education and Care (formerly Office of Child Care Services) and on Caring For Our Children: National Health and Safety Performance Standards: Guidelines for Out-Of-Home Care, developed by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care. Caring For Our Children can be accessed and fully utilized on line at http://nrc.uchsc.edu/CFOC/ . For additional information/resources on health and safety, please visit the Massachusetts Department of Public Health website at www.mass.gov/dph/.

Note: The entire Health and Safety section has been formatted as a checklist and can be used as a stand-alone section for facility checks and general supervision monitoring.

A. Health Care Consultant

☐ The Early Intervention program has either a physician or registered nurse with pediatric or family health training and/or experience, as the program's health care consultant. The consultant assists in the development of the program's health care policy and approves and reviews the policy at least every two years. The consultant approves the first aid training for the staff, is available for consultation as needed, and approves any changes in the health care policy. The Health Care Consultant's name and contact information is readily available. (See E.1.b. of this section).

B. Health Care Policies

The program has written health care policies and procedures that protect the health and welfare of children, staff and families. All staff members are trained in such procedures and families receive copies of appropriate policies and procedures as requested. The written health care policy includes, but is not limited to, the following plans and/or procedures:

☐ 1. A plan for the management of infectious diseases. The plan includes:

☐ a. Criteria regarding signs or symptoms of illness which will determine whether a child or staff member will be included or excluded from activities.

☐ b. Policies for when a child or staff member who has been excluded from activities may return.

☐ c. Policies regarding the care of mildly ill children in attendance at a non-home-based activity including special precautions to be required for the following types of infectious diseases: gastro-intestinal, respiratory and skin or direct contact infections, until the child can be taken home or suitably cared for elsewhere.

☐ d. Procedures for notifying parents when any communicable disease, such as measles or salmonella, has been introduced to the group

☐ 2. A plan for infection control. Procedures are written to include:

☐ a. directions for proper hand washing techniques

☐ b. instructions on the care of toys and equipment

☐ 3. A plan for the control of diseases spread by blood products and body fluids. Procedures are written to include:

☐ a. Universal precautions, including the requirement that staff use single-use latex-free gloves when they are in contact with bodily fluids and that contaminated materials are cleaned or disposed of properly.

☐ b. Annual training in blood-borne diseases including hepatitis B, C and HIV

☐ c. An exposure control plan

☐ d. Staff are offered a hepatitis B vaccine series at the time of hire

☐ 4. A procedure for reporting suspected child abuse or neglect to the Department of Social Services. The procedure includes assurances that:

☐ a. As mandated reporters all staff will immediately report suspected child abuse or neglect to the Department of Social Services pursuant to M.G.L. c. 119 § 51A, and to the program's director or designee

☐ b. The program director or designee will notify the Department of

Public Health, Early Intervention Services, immediately after filing a 51A report, or learning that a 51A report has been filed, alleging abuse or neglect of a child by a member of the EI program's staff.

☐ c. The program develops and maintains written procedures for addressing any suspected incident of child abuse or neglect that includes but is not limited to ensuring that an allegedly abusive or neglectful staff member does not work directly with children until the Department of Social Services investigation is completed or for such a time as the Department of Public Health requires.

C. Staff Requirements

☐ 1. Within the first six months of hire, all direct care staff members obtains and maintains current certification in CPR that specifically addresses infants and toddlers. The CPR curriculum includes the management of a blocked airway and rescue breathing.

☐ 2. Within the first six months of hire, all direct care staff members obtain and maintain current certification in pediatric first aid. The core elements of pediatric first aid training are outlined in Caring For Our Children, Standard 1.027.

3. Prior to the initiation of any direct contact with families, new staff, regularly scheduled volunteers and student interns must present to the program director evidence of:

☐ a. A physical examination within one year prior to employment. The physical examination is valid for two years from the examination date and will be repeated every two years thereafter.

☐ b. Immunity for measles, mumps, and rubella in accordance with MDPH regulations. (See www.mass.gov/dph). Such evidence is not required of any person who states in writing that vaccination or immunization conflicts with his/her sincere religious beliefs, or if it is medically contra-indicated.

☐ c. Negative Mantoux TB test in accordance with current Department of Public Health regulations

☐ d. Statement of physical limitations in working with children.

☐ 4. A CORI evaluation is completed on, and documented in the personnel file of each person with the potential for unsupervised contact with children in accordance with current DPH requirements 105 CMR 950.: Criminal Offender Record Information Checks

D. Staff Health and Safety

1. ☐ The program provides for the reasonable safety of staff while providing services. This may include recommendations to staff regarding phoning families before visits, providing staff in-service training on safety issues.
2. ☐ The program provides updated information to staff regarding communicable diseases, preventive health policies, and environmental health risks.
3. ☐ The program provides a copy of the Health and Safety section of these standards at annual staff trainings on health and safety issues.

E. Community Based Program Policies

Early Intervention services, not including those services provided in children's homes, are provided in settings that are safe, that support the optimal development of infants and toddlers, and that are conducive to community collaboration. Such settings are welcoming to young children and their families, and are often part of a naturally occurring family routine. It is critical that settings where young children spend time be carefully evaluated to ensure the health and safety of children, staff, and families participating in EI activities

1. All EI programs, regardless of where activities take place, must have the following information readily available:

☐ a. The current DPH Early Intervention program certification **and**

☐ The Department of Early Education and Care (EEC) (formerly OCCS) license or written documentation of exemption. The program must be licensed by EEC if it meets the current EEC requirements. If the program does not meet these requirements and does not have an EEC license, an Early Intervention Program facility check must be completed by DPH for any site where non-home based services are provided. It is the program's responsibility to notify EEC in the event their status changes and licensing is required. For a lead site, the Early Intervention Program facility check must be completed. For a shared or participatory site, the Community Group Facility Approval Form must be completed when caregivers will not be present.

☐ b. There is a telephone/intercom system readily available for emergencies. The following information is immediately visible at each telephone:

☐ the name, and telephone number of the health care consultant; the telephone numbers of the

- ☐ fire department
- ☐ police department
- ☐ Poison Control Center
- ☐ ambulance service
- ☐ nearest emergency health care facility
- ☐ DPH central and regional offices
- ☐ telephone number and address of the program, including the location of the program in the facility

☐ c. Location of the health care policy and first aid kit.

☐ d. Updated allergy and/or other emergency medical information for each child.

☐ e. Emergency preparedness plan.

☐ f. Evacuation procedures next to each exit.

☐ g. Diapering and toileting procedures.

☐ h. Weekly snack menu. (Not required if provided by individual parent for his/her own child.)

☐ i. Current activity schedule.

☐ j. Behavior management policy.

☐ k. The Program maintains daily attendance records for EI-enrolled and community children that indicate each child's attendance, arrival and departure times.

2. EI staff obtain or have access to information from parents regarding:

☐ a. The child's daily schedule, developmental history, sleeping and play habits, favorite toys, accustomed mode of reassurance and comfort

☐ b. Procedures for toilet training of the child, if appropriate

☐ c. The child's eating schedule and eating preferences, where appropriate, including handling, preparation and feeding for unique dietary needs

☐ 3. The program has written procedures in place to be followed by EI staff to communicate with parents on a regular basis.

☐ 4. The program has written procedures to be followed in case of illness or emergency. These procedures include method of transportation and notification of parents, as well as procedures when parent(s) cannot be reached. In addition programs shall obtain:

☐ a. An emergency phone contact for every child whose caregiver is not present

☐ b. An emergency contact for caregivers who are present

☐ c. Written parental consents for emergency first aid and transportation to a specific hospital in emergencies

☐ d. Written parental consent specifying any person authorized to take the child from the program or receive the child at the end of an activity

☐ e. If parent not present, parental permission must be obtained for child to participate in activities at various community locations (e.g. library, playground)

☐ f. Additional parental consent for any field trips not on list above

☐ 5. The program maintains adequate first aid supplies and

☐ has a procedure for the use, storage and transportation of first aid supplies. A portable first aid kit must accompany staff on all non-home based activities. (See Standard 5.093, First Aid Kits, Caring For Our Children).

6. The program has a written injury reporting policy that includes, but is not limited to:

☐ a. An injury report that includes the name of child, date, time and location of accident or injury, description of injury and how it occurred, name(s) of witness(es), name(s) of person(s) who administered first aid or medical care and first aid or medical care required

☐ b. The written policy for informing parents, in writing, within 24 hours, of any first aid administered to their child and immediately informs them of any injury or illness that requires care other than first aid

☐ c. The assurance that the injury report shall be maintained in the child's file

☐ d. The maintenance of a central log or file of all injuries which occur during program hours and the policy for periodically monitoring the safety record of the program to identify problem areas

The following sections apply only when services are being provided in a lead site (as defined in Section II of these standards).

☐ There is a staff person certified in first aid and CPR on site when children are present.

☐ The program has a procedure for the care of mildly ill children at the site. The plan shall include, but not be limited to, meeting individual needs for food, drink, rest, play materials, comfort and appropriate indoor activity.

☐ (1) The program shall provide a quiet area for mildly ill children.

☐ (2) Where mildly ill children are cared for in a separate space or room, the program is permitted to care for mixed age groups of children, provided that the staff ratio for the youngest child in the group is met at all times.

(3) Staff who are assigned to care for mildly ill children in a separate space or room are trained in the following areas:

☐ (a) general practices and procedures for the care and comforting of the mildly ill children

☐ (b) recognition and documentation of symptoms of illness

☐ (c) taking children's temperature

☐ e. The program does not permit smoking in the EI site.

☐ f. The program does not permit hot liquids in the presence of children.

☐ g. The program has developed procedures for injury prevention and management of medical emergencies during field trips.

☐ The program ensures that a first aid kit and the list of emergency numbers for the children are available on any field trip.

☐ 7. The program has a written plan for administration of medication. The program may accept written parental authorization for specific non-prescription topical medications to be administered.

☐ a. Topical medications such as petroleum jelly, diaper rash ointments, and anti-bacterial ointments which are applied to wounds, rashes, or broken skin must be stored in the original container, labeled with the child's name, and used only for that individual child.

☐ b. Topical medications such as sunscreen, bug spray, and other ointments which are not applied to open wounds, rashes, or broken skin may be generally administered to children with written parental authorization.

☐ 8. The program develops with the family a written medical care plan for meeting individual children's specific health care needs, including the procedure for identifying children with allergies and protecting children from exposure to foods, chemicals, or other materials to which they are allergic.

9. The program has written Preventive Health Care Procedures which address the following:

☐ a. The program does not admit a child or staff member who has a diagnosed communicable disease (which cannot be contained by Universal Precautions) during the time when it is communicable. ☐ The program notifies all parents and participants when any communicable disease, such as measles, mumps and chicken pox has been introduced to the group.

☐ b. The program monitors the environment daily to immediately remove or repair any hazard that may cause injury.

☐ c. The program keeps all toxic substances, poisonous plants, medications, sharp objects, matches, and other hazardous objects in a secured place out of reach of children.

☐ d. Program health records include each child's annual physical and immunization records. (See Appendix Z, Caring For Our Children).

☐ (1) All children enrolled in EI are up to date on immunizations according to the recommendation of the Massachusetts Department of Public Health, unless the child's parent has stated in writing that vaccination or immunization conflicts with his/her sincere religious beliefs or if the child's physician has stated in writing that the vaccination or immunization is medically contraindicated.

☐ (2) The program enrolls a child in community-based Early Intervention activities only if provided with a written statement from a physician which indicates that the child has had a complete physical examination (which includes screening for lead poisoning) within one year prior to admission, or obtains one within one month of admission or obtains written verification from the child's parent(s) that they object to such an examination on the ground that it conflicts with their sincere religious beliefs.

☐ (3) All EI-enrolled children are screened for lead at least once between the ages of nine and twelve months and annually thereafter until the age of

thirty-six months. For all children enrolled in Early Intervention prior to nine months of age, a statement signed by a physician that the child has been screened for lead is obtained by the EI program.

☐ 10. The program has written procedures for regular toileting and diapering of children and for disposal/cleaning of soiled clothing, diapers and linens. ☐ The program maintains at least one toilet and washbasin in one or more well ventilated bathrooms.

☐ a. Handwashing procedures are posted. (Handwashing Procedure, Standard 3.021, Caring For Our Children).

☐ b. A diapering plan is posted. (Diaper Change Procedure, Standard 3.014, Caring For Our Children).

☐ c. There is a disposable diapering surface.

☐ d. There is a covered, lined trash container for soiled diapers.

☐ e. When adult toilets and washbasins are used, the program provides non-tippable stairs to permit access by those children who are able to use them. In addition to toilets, portable "potty chairs" may be used in the bathroom or separate room for children unable to use toilets.

☐ f. Potty chairs, if used, are cleaned and disinfected after each use.

☐ g. If cloth diapers are used, a flush sink or toilet for rinsing diapers and a hand washing facility is provided convenient to the diaper changing area.

☐ h. Special handrails or other aids shall be provided if required by special needs children.

☐ i. The program provides both hot and cold running water in washbasins and for water used by children.

☐ j. There is a temperature control to maintain a hot water temperature at no more than one hundred twenty (120) degrees Fahrenheit.

☐ 11. Food provided at the site is nutritionally and developmentally appropriate for children.

☐ a. The program follows parental or physician's orders in preparation or feeding of special diets to children and follows the directions of the parents in

regards to any food allergies of the child or where vitamin supplements are required.

☐ b. The program prepares nutritious and tasteful snacks in a manner that makes them appetizing.

☐ c. The program stores, prepares and serves all food and beverages in a manner that ensures that it is free from spoilage and safe for human consumption.

☐ The program provides refrigeration and storage for food at not less than 32°F or more than 45°F for food requiring refrigeration.

☐ The program stores all food in clean, covered containers.

☐ The program disposes milk, formula or food unfinished by a child.

☐ d. The program provides tables and chairs for use by children while eating which are of a type, size and design appropriate to the ages and needs of the children. ☐ When feeding tables or highchairs are used, they are designed to prevent children from falling or slipping. ☐ The program washes and disinfects the tables or highchair trays used by the children for eating before and after each meal. ☐ The eating area is clean, well-lit and well-ventilated.

☐ e. The program provides eating and drinking utensils that are appropriate to the age and developmental needs of the children.

☐ (1) Eating and drinking utensils are free from defects, cracks and chips.

☐ (2) Disposable cups and plates may be used, but if plastic silverware is used, it shall be heavy duty and dishwasher safe.

☐ (3) All reusable eating and drinking utensils are thoroughly washed and sanitized before reuse.

☐ f. The program provides a source of sanitary drinking water located in, or are convenient to, rooms occupied by children.

12. Requirements for Pets

☐ The program selects pets for the center that are developmentally appropriate for children. Before children are exposed to any animal, staff shall consider the effect on children's health and safety, with special attention to children with

compromised immune systems and other vulnerabilities. **Under no circumstances should children come into contact with reptiles at the EI program.** (See Public Health Fact Sheet – Salmonellosis from Reptiles, www.mass.gov/dph).

13. Physical Facility:
All lead sites must have the following:

☐ (1) A current Building Certificate of Inspection. The Building Certificate of Inspection:

☐ is signed by the building inspector in conjunction with the local fire inspector

☐ states capacity of room

☐ lists an expiration date.

If the program site offers toddler groups (without caregivers present), the Building Certificate of Inspection:

☐ is specific to those rooms used for services and

☐ specifies "Code I-2 Usage" (indicating children under 2.9 years) and "E Usage" (children over 2.9 years) or states "infants and toddlers."

☐ The certificate of inspection certifies that the program's site complies with the State Building Code (780 CMR 633.0)

☐ (2) Documentation that the site is lead free.

(a) For a facility built prior to 1978, the program provides evidence of a lead paint inspection from the local board of health, or the Massachusetts Department of Public Health, or a private lead paint inspection service and compliance with 105 CMR 460.000 (Department of Public Health Prevention and Control of Lead Poisoning regulations).

(b) For a facility built after 1978, the program provides documentation of the construction date.

(c) The program removes and covers any chipping, flaking or otherwise loose paint or plaster.

(3) Programs are required to have at least one site that is accessible as defined in the Americans with Disabilities Act (ADA). The site must be accessible in all areas (including bathrooms) to children, staff and caregivers. If not accessible, an action plan with timelines to address the deficiency is filed with the Department of Public Health.

☐ The program has at least one site that is accessible as defined in the Americans with Disabilities Act **OR**

☐ The program has an action plan with timelines to address the accessibility issue.

(4) ☐ The program has a policy and procedures for regularly scheduled evacuation drills.

☐ The program holds practice evacuation drills at least every other month, at different times of the group schedule.

☐ The program documents the date, time and effectiveness of each drill.

☐ The program develops specific procedures to be followed for evacuating children with disabilities, and for infants and toddlers.

☐ The program develops specific written contingency plans and procedures to deal with fire, natural disasters, and loss of power, heat, or water.

☐ There is documentation that each staff person has participated annually in at least one evacuation drill.

☐ (5) The program facilities are asbestos safe.

(6) Indoor space meets the following requirements:

☐ The program shall have a minimum of 40 square feet of **activity space** per child, exclusive of hallways, lockers, wash and toilet rooms, isolation rooms, kitchens, closets, offices or areas regularly used for other purposes.

☐ There is a comfortable, non-intrusive space where parents and visitors can observe play groups.

The exit from each room is ☐ clearly marked and ☐ clear of obstructions.

☐ (a) Floors of rooms used by children are clean, unslippery, smooth and free from cracks, splinters and sharp or protruding objects and other safety hazards.

☐ (b) Ceilings and walls are maintained in good repair, and are clean and free from sharp or protruding objects and other safety hazards.

☐ (c) All steam and hot water pipes and radiators are protected by permanent screens, guards, insulation or any other suitable device which prevents children from coming in contact with them.

☐ (d) All electrical outlets that are within the reach of children are covered with a safety device when not in use. If the covering is a shock stop, it shall be of adequate size to prevent a choking hazard.

☐ The play space is well-ventilated.

☐ (e) Room temperature in rooms occupied by children are maintained at a draft-free temperature of not less than sixty-five (65) degrees Fahrenheit at zero degrees temperature outside; and at not more than outside temperature when the outside temperature is above eighty (80) degrees Fahrenheit.

☐ (f) There is designated space, separate from children's play or rest areas, for administrative duties and staff or parent conferences.

☐ There is an individual workspace for each fulltime staff person.

☐ (g) There is sufficient space, accessible to children for each child to store clothing and other personal items.

☐ (h) The interior of the building is clean and maintained free from rodents and/or insects. ☐ The program employs integrated pest management as necessary, and notifies families in advance of any pest management that is planned.

☐ (i) The program provides suitable guards across the insides of any windows that are accessible to children and present a hazard. ☐ The program provides suitable guards across the outside of basement windows abutting outdoor play areas.

☐ (j) Guards are placed at the top and bottom of stairwells opening into areas used by children. **Pressure gates may not be used at the top of stairs.**

☐ (k) Routine, major housekeeping activities such as vacuuming, washing floors and windows are not be carried on in any room while it is occupied by children.

☐ (l) The program provides a barrier, such as a door or gate, which prevents children's access to the kitchen while unsupervised.

☐ (m) The kitchen is maintained in a sanitary condition and garbage receptacles used in the kitchen are emptied and cleaned daily.

☐ (n) All toileting and diapering areas are away from food handling areas.

☐ (o) The program maintains eating areas that are sufficiently large to fit tables and seats for children eating in an uncrowded manner, and are clean, well-lit and ventilated.

☐ (p) Working smoke detectors are present.

☐ (q) Fire extinguishers are present and are

☐ accessible and ☐ charged.

☐ (r) Automatic sprinkler system is present (not required).

☐ 7. The program maintains, or has access to, an outdoor play area of at least 75 square feet per child using it at any one time, including those with disabilities. (The outdoor play area is not a requirement when children are in attendance at the program site less than 4 hours per day). ☐ Outdoor play areas are accessible to young children and to children with disabilities.

☐ (a) The outdoor play area is accessible to both direct sunlight and shade.

☐ (b) The average width of such a play area is not less than eight feet.

☐ (c) The outdoor play area is free from hazards including but not limited to: a busy street, poisonous plants, water hazards, debris, broken

glass, and any such hazard is fenced by a sturdy, permanently installed barrier which is at least four feet high or otherwise protected.

☐ (d) If the outdoor play area is located on a roof, it is protected by a non-climbable barrier at least seven feet high.

☐ (e) The outdoor play area is not covered with a dangerously harsh or abrasive material and the ground area under swings, slides climbing equipment, seesaws, etc., is not paved or is covered with mats.

☐ (f) Pea gravel and wood chip nuggets are not used.

☐ (g) The ground area and fall zones under swings, slides, and climbing structures are covered with an adequate depth of an impact absorbing material.

14. Equipment:

☐ a. The program uses only equipment, materials, furnishings, toys and games that are appropriate to the needs and developmental level of the children. ☐ They are sound, safely constructed, flame retardant, easily cleaned, and free from lead paint, protruding nails, rust and other hazards that may be dangerous to children.

☐ b. The program keeps all equipment, materials, furnishings, toys and games clean and in safe workable condition.

☐ c. Equipment is sturdy, stable and non-tippable.

☐ d. Water play containers and toys are sanitized daily.

☐ e. Some materials and equipment are visible and readily accessible to the children in care and shall be arranged so that children may select, remove and replace the materials either independently or with minimum assistance.

☐ f. There is adequate storage for playgroup materials and equipment.

☐ g. The program provides equipment and materials that reflect the racial and ethnic composition of the children enrolled.

15. Transportation:

☐ a. EI Staff members are familiar with DPH Transportation Standards

b. Transportation drop of point is

☐ off street with loading/unloading zone **OR**

☐ on street with enforces designated parking space for handicapped loading/unloading

☐ c. There is adequate, interior protected, secure storage space for car seats.

☐ d. The car seat storage space is readily accessible to drivers.

☐ e. The drop off point is within view of program staff or there is a system for drivers to communicate (i.e., buzzer).

☐ f. Staff meets transportation vehicles at the drop off point.

☐ g. Transportation concerns are promptly reported.

XII. Program Administration

A. Early Intervention programs must have a full-time primary program administrator. A primary program administrator may be a Program Director or Program Coordinator and must meet the credentialing requirements for one of the disciplines listed in Section V. of these standards. If the administrative responsibilities are shared within an agency, a written administrative plan is developed, designating specific roles and responsibilities to named individuals. The primary program administrator is required to apply for Early Intervention Program Director Certification within three years of assuming that position.

B. Each Early Intervention program has an organizational plan and written policies addressing processes and procedures that are readily available.

1. A written administrative organizational plan that designates the person/persons responsible for:
   - a. Administrative oversight
   - b. Program development
   - c. Budget development and oversight
   - d. Program evaluation
   - e. Staff development
   - f. Hiring, review and termination of staff
   - g. Clinical program supervision
   - h. Linkage to vendor agency
   - i. Linkage to lead agency
   - j. Designation of administrative coverage during hours of operation
   - k. Facilitation of family involvement and linkage between staff and parents
   - l. Approval and assistance in developing health care policies for the program (either a physician or registered nurse)
   - m. Coordination of transportation issues and the processing of transportation forms and reports

2. Policies addressing staff rights and responsibilities including:
    a. Salary
    b. Basis for evaluating performance
    c. Benefits
    d. Scheduled holidays/vacations
    e. Conditions for immediate discharge
    f. Grievance procedure
    g. Resignation procedure
    h. Job responsibilities as per individual program job description or contractual arrangements
    i. Professional development
    j. Program hours of operation
3. Personnel records for each staff member, which includes but are not limited to:
    a. Employee's resume or job application
    b. Documentation that the employee has met the credentialing requirements
    c. Record of reference verification
    d. Documentation of completed CORI evaluation
    e. Health records as required in Section XI, C of these standards
    f. Documentation of training required to meet core competencies
    g. Annual performance evaluations
    h. Documentation of EI certification status
4. The following written procedures are available to any interested party on request:
    a. Referral
    b. Intake
    c. Determination of eligibility (evaluation)
    d. Assessment
    e. IFSP development
    f. Service delivery modes
    g. Transition
    h. Discharge

i. Maintenance, management and preservation of client records in accordance with the due process procedures found in Appendix B of these standards.

j. Release of record with written parental consent

k. Guidelines for referral to specialty providers and services

The record kept on each individual child contains the following:

a. Access sheet for recording those authorized persons who have reviewed a record

b. Signed parental consent forms

c. Documentation of referral

d. Completed DPH EIIS (Early Intervention Information System) Forms – Referral, Eligibility Evaluation, IFSP, Discharge

e. Intake and background information

f. Medical information

g. Reports from other agencies and professionals, as applicable

h. Results of evaluations and assessments

i. IFSPs

j. Documentation of contacts with child and family including date, service type, duration and content of contact, and the legible signature and discipline of the staff person signing the note

C. Program staff members are available by phone during regular business hours. Telephone answering machines or voice mail do not satisfy this requirement.

Early Intervention Program Core Team

1. An Early Intervention Program has a minimum of three core team members, each of whom must work at least 30 hours per week. The core team is comprised of a Developmental Specialist (a through c) and two other professionals representing different disciplines as defined in Section V., B, 2 – 7

of these standards. In addition to the core team, an Early Intervention program will have a full time director/coordinator.

If at any time following the initial program certification, the staffing of the program does not meet the requirements for a core team, the program director will notify the Regional Early Intervention Specialist in writing of the absence of a core team. The program will be given sixty days from the first day of noncompliance to regain compliance of this requirement. Families enrolled in the program will be notified in writing of the absence of a core team for the timeframe this situation exists and of the options available to them for comprehensive Early Intervention services. Families will also be given a copy of Family Rights in Early Intervention at this time. A copy of the written notice to families will be submitted to the Regional Early Intervention Specialist for review before distribution and a copy of the notification filed in each child's record. If a core team is not in place at the end of the sixty-day period, a program certification review will take place.

Early Intervention programs are grounded in child development and serve young children and their families within the context of understanding the full spectrum of child development. Therefore the Developmental Specialist serves a critical function within the EI core team. Early Intervention programs must employ at least one Developmental Specialist (a, b or c) [who works at least 30 hours per week] for the first 75 enrolled children. For each additional 75 enrolled children, an additional 30 hours per week of Developmental Specialist (a, b or c) time is required. These additional hours of Developmental Specialist time may be a combination of part-time staff.

E. Early Intervention programs are expected to comply with the submission of data requested by the Department of Public Health within the timelines established. Timelines for Early Intervention EIIS Forms:

Referral Form –

Within 10 days of the first face-to-face meeting with the family.

Eligibility Evaluation Form –

- Within 10 days of a completed eligibility evaluation if the child is deemed ineligible.
- Within 10 days of the IFSP signature if the child has an IFSP.

IFSP Form –

Within 10 days of IFSP signature

Discharge Form –

a. Child receives intake visit only; family declines eligibility evaluation or program loses contact with family following the intake visit – Discharge Form – within 10 days of inactive date or date of intake visit.

b. Child receives a completed eligibility evaluation and is deemed ineligible. – Discharge Form within 10 days of date of eligibility evaluation.

c. Child has received a completed eligibility evaluation but family declines services or program loses contact with family – Discharge Form within 10 days of inactive date or date of eligibility evaluation.

d. Client has received ongoing IFSP services – Discharge Form within 10 days after the inactive date or last date of active service. (Eligible children may receive services up to but not on their third birthday).

F. Each program conducts an annual self-evaluation. Programs encourage families to participate in this self-evaluation that should include areas such as:

1. Feedback on staff performance
2. Evaluation of program services
3. Review of IFSP process
4. Review of transition procedures
5. Approaches to family participation
6. Review of health and safety procedures
7. Review of interagency agreements and service contracts

G. Each program develops a written procedure for the internal resolution of complaints. Any family with a complaint must be informed again (as they were at intake, see Section VI.B. 2) of procedural safeguards and family rights. Families must also be informed of their option to speak to Department of Public Health personnel and/or file a formal written complaint. At the time of the family's complaint, a copy of the Family Rights and Early Intervention Services brochure is given to the family. Due process procedures for families enrolled in Early Intervention are outlined in Appendix B of these standards.

H. Fees

1. Department of Public Health policies call for the collection of an Annual Fee. The fee is assessed for all children with a signed IFSP based on family size and annual income according to the current fee structure.

This fee is applied to all IFSP services with the exception of those services that are exempt from charge per IDEA, Secs. 303.520 and 303.521.

2. The services to be rendered and the corresponding costs for such services are referenced in the Department of Public Health Early Intervention Billing Instructions and payable according to the rate structure defined by the Massachusetts Division of Health Care Finance and Policy (formerly known as the Massachusetts Rate Setting Commission.) Services, as appropriate, may be billed to the Department of Public Health, the Division of Medical Assistance, and other third party payers.

3. Each program must assure that no fees are charged for the services that a child is otherwise entitled to receive at no cost to parents. Programs must also assure that the inability of parents of an eligible child to pay for services will not result in the denial of services to the child or the child's family.

4. Each program must assure that services will not be delayed or denied to any child because of disputes between agencies regarding financial or other responsibilities.

5. The Department of Public Health hereby assures that the following services will be carried out at public expense and for which there will be no fees charged to parents:

- Implementing the child find requirements
- Evaluation and assessment including the functions related to evaluation and assessment
- service coordination
- Administrative and coordinating activities related to the development, review, and evaluation of IFSPs
- Implementation of the procedural safeguards, dispute resolution and due process

XIII. Request for Waiver

A. Request for waiver from these standards may be made by submitting a written request on the DPH Waiver Request Form to Early Intervention Services, Massachusetts Department of Public Health.

B. The Massachusetts Department of Public Health retains the authority to allow or deny the request.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

EARLY INTERVENTION OPERATIONAL STANDARDS

APPENDIX A:

INTERAGENCY AGREEMENTS

The Commonwealth of Massachusetts • *Department of Education*
• *Executive Office of Health and Human Services* • *Department of Public Health*

U. S. Department of Health & Human Services
Administration for Children and Families • Region 1

TO: Superintendents of Schools
Special Education Directors
Early Intervention Program Directors
Head Start Directors
Child Care Directors
Child Care Resource & Referral Agencies
Advocacy Organizations
Parent Advisory Councils

FROM: Robert V. Antonucci, Commissioner, Department of Education
David H. Mulligan, Commissioner, Department of Public Health
Susan L. Costello, Interim Secretary, Executive Office of Health & Human Services
Hugh Galligan, Administrator, Region 1 Office of the Administration for Children and Families

DATE: November 30, 1994

RE: Interagency Policy on Early Childhood Transitions

Over the course of the last year representatives from the Department of Education, the Department of Public Health, Head Start and Child Care worked together to revise the *Policy on Early Childhood Transitions,* which has been in effect since 1990. The policy was revised after eliciting input from the public through regional forums and written comment on the proposed draft Amendment to the policy. Implementation of the enclosed *Policy of Early Childhood Transitions* will take effect immediately.

The most significant change to the 1990 policy is related to the transition of children who turn three in the late spring and summer. The policy now requires that a child in an Early Intervention program who is eligible for special education services has an Individualized Education Plan (IEP) developed by the child's school district in place, with special education services provided by the school district in accordance with the IEP, commencing on the child's third birthday.

The goal of the policy continues to be the provision of a smooth transition for young children moving from state sponsored Early Intervention programs to community early childhood programs.

We support the premise the policy is based on: that local serve providers, who know the children, their families and the services available, are most effective in developing specific procedures and activities to assure a smooth transition for the child and the family.

The purpose of the policy is to provide a framework for collaboration and for joint planning for the transition of young children, with or at risk of special needs, among local agencies that provide services to young children and their families. We support the concept of collaboration and stress the need for ongoing communication and the use of local interagency councils to carry out the transition process.

Because we believe that all agencies concerned with young children should assume joint responsibility for the methods and means of implementing this policy at both the local and state level, a lead agency is not specified. Effective implementation of the policy is an important step towards developing a seamless system of services for young children.

If you have any questions regarding the policy or need assistance in implementing the policy please contact Ron Behanm, Director of Early Intervention Services, Department of Public Health at (617) 624-5969 or Elisabeth Schaefer, Administrator of Early Learning services, Department of Education at (781) 388-3300, Ext. 341.

ADDENDUM TO AGREEMENT
BETWEEN THE MASSACHUSETTS DEPARTMENT OF EDUCATION,
REGION 1 OFFICE OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES,
THE MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES,
AND THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

CONCERNING INTERAGENCY DISPUTE RESOLUTION
RELATING TO EARLY CHILDHOOD TRANSITIONS

The Department of Education, the Region 1 Office of the Administration for Children and Families, the Executive Office of Health and Human Services and the Department of Public Health are committed to facilitating smooth transitions for young children with or at risk of having special needs and their families.

The purpose of this memorandum of agreement is to outline procedures to be followed by the signatory parties to the Policy on Early Childhood Transitions should disputes arise.

1. The Department of Public Health assures that in the event of a dispute among public agencies regarding responsibility for payment for early intervention services, the Department of Public Health shall assume responsibility for such payment consistent with M.G.L. 111G;

2. The Department of Education (DOE), the Region 1 Office of Administration for Child and Families (ACF), and the Department of Public Health (DPH) shall be responsible for resolving their own internal disputes in a timely manner. Internal agency disputes which are not resolved in a timely manner and intra-agency disputes shall be referred to a committee consisting of the Chairpersons of the Interagency Coordinating Council, the Early Childhood Advisory Council, the Regional Head Start Program Manager, the Director of Early Learning Services at the Department of Education and the Director of Early Intervention Services at the Department of Public Health. Decisions made by this committee shall be final and shall be binding upon DOE, ACF and DPH. The procedures to be utilized by this body are as follows:

a. The DPH shall convene this committee for the purpose of dispute resolution within 10 days of identification of the disputed action.

b. Participating parties shall resolve disputes by consensus. If consensus is not rendered by stated parties within a one month time frame, a simple majority vote shall be taken.

This agreement shall be effective upon the Commonwealth of Massachusetts' participation in the ninth and succeeding years of participation under P.L. 102-119, Part H.

This agreement may be amended through negotiations between the signing parties.

Robert V. Antonucci 7/26/95
Robert V. Antonucci Date
Commissioner
Department of Education

David H. Mulligan 7/24/95
David H. Mulligan Date
Commissioner
Department of Public Health

Hugh H. Galligan 7/24/95
Hugh Galligan Date
Administrator
Region 1 Office of the
Administration for Children and
Families

Gerald Whitburn Date
Secretary
Executive Office of Health
and Human Services

In acknowledgement of the importance of establishing comprehensive, well-defined procedures for coordinating the transitions of young children and their families as they move from one service agency to another, I endorse this policy and the concept of interagency collaboration.

Robert V. Antonucci 11/28/94

Robert V. Antonucci Date
Commissioner
Massachusetts Department of Education

David H. Mulligan Date
Commissioner
Massachusetts Department of Public Health

Hugh Galligan 11/29/94

Hugh Galligan Date
Administrator
Region 1 Office of the Administration for Children and Families

Susan L. Costello 11/30/94

Susan L. Costello Date
Interim Secretary
Massachusetts Executive Office of Health & Human Services

POLICY ON EARLY CHILDHOOD TRANSITIONS

Massachusetts Department of Public Health
Massachusetts Department of Education
Region 1 Office of the Administration for Children & Families
Massachusetts Executive Office of Health and Human Services

1994

FOREWORD

The Department of Education, the Department of Public Health, the Executive Office of Health and Human Services and the Region 1 Office of the Administration for Children and Families are committed to facilitating smooth transitions for young children with or at risk of having special needs and their families.

This policy has been written by the Massachusetts Department of Education and the Department of Public Health, and is supported by the Executive Office of Health and Human Services, and Head Start (Region 1 Office of the Administration for Children and Families). This policy is based on the idea that local service providers, who know the children, their families, and the services available, are most effective in developing procedures and activities to support the child and the family during transitions. The purpose of this policy is to provide a framework for increased collaboration and joint planning for transitions among agencies serving young children.

TRANSITION POLICY

Comprehensive, well-defined procedures for coordinating the uninterrupted transition from an infant-toddler program to a preschool age program, and then to a kindergarten program, are essential to the educational adjustment and development of a young child with special needs and the well-being of the child's family.

Building upon what has been learned through various initiatives across the state, this policy has been developed to address transitions during the early childhood period. It is designed to have a positive impact on planning, delivery and evaluation of transition practices and to increase the comprehensiveness and usefulness of transition procedures. The intent of this information is not to mandate any one set of transition procedures but to provide guidelines in three targeted areas for local level decision-makers to address as they develop transition plans. These areas of focus include the CHILD, the FAMILY and the AGENCIES.

We support the concept of collaboration as well as the use of existing interagency councils in carrying out the transition process. Because we believe early childhood agencies should assume joint responsibility for the methods and means of implementing this policy at both the local and state levels, a lead agency has not been specified in this document.

FOCUSING ON THE CHILD

For the child, a collaboratively developed transition plan should decrease disruption and gaps in services and enhance the child's adjustment to new settings. Identification of adaptive equipment needs and classroom modifications, opportunities to visit new programs prior to entry, as well as joint assessments and observations, will facilitate the child's ability to participate in the new setting.

Guidelines to enhance a child's transition to the new setting(s) include the following:

- Establish a process which involves parents (*) as well as staff from both the sending and receiving agencies in identifying what is known about the child, what needs to be known, and procedures for gathering further information to avoid duplication of assessments, evaluations, and resources.

- Identify and plan for all adaptive equipment and transportation needs in the receiving program(s).

- When possible and appropriate, arrange for teachers or other appropriate staff persons from the receiving program(s) to observe the child in the sending program's setting and encourage sharing of information about a child's strengths and needs, as well as effective teaching and adaptive strategies by parents and teachers.

- Devise activities to assist the child in adjusting to the new settings, such as arranging pre-placement visits for the child, and arranging for parents, therapists or other appropriate staff persons to observe and/or visit.

(*)Where the word "parent" appears, it should be considered to apply equally to the legal guardian.

FOCUSING ON THE FAMILY

For the family, a collaboratively developed transition plan will provide ongoing opportunities for parent involvement. A plan that accommodates the needs and preferences of parents, and defines the process for meeting the needs of their child during the transition to new programs, will alleviate the anxiety and stress that frequently accompany change.

Recognizing that parents are the most effective advocates for their children, both sending and receiving agencies should include the following components in involving families:

- Involve parents in jointly designing and providing parent training. Training activities need to address the following issues:
    - Referral information and eligibility requirements for community early childhood programs
    - The federal Individuals with Disabilities Education Act
    - The Massachusetts Special Education Law
    - Rights and responsibilities of parents under state and federal special education laws
    - Community resources for advocacy and support
    - Other subjects identified by parents
- Training should be offered as needed, and may include representatives from parent training and advocacy groups, parents who have been through similar transitions with their children, and representatives from the range of local agencies that provide services to young children.
- Offer an opportunity for parents to visit preschool settings which are possible options for the child's future placement.
- Offer an opportunity for parents to meet with both the sending and receiving program staff to share information, answer questions and discuss what and when specific events will occur in the transition process.
- Once placement in the receiving program has been established, a plan should be developed for ongoing family involvement which is culturally sensitive to and consistent with each family's needs and preferences.

FOCUSING ON AGENCIES

For agencies, a collaboratively developed transition plan helps to promote positive, cooperative interactions. Such a plan will facilitate a smooth transition process, with local agencies sharing the responsibilities involved, thus minimizing the burden of the process on any single agency. As agencies begin to collaborate, problems may arise; however, ongoing communication and formal planning among agencies serving young children will increase both knowledge and appreciation for each other's services as well as diminish duplication of effort.

A transition process reflecting the principles in this document should be developed to provide a framework for all sending and receiving agencies (*) serving children having or at risk of having special needs from birth to five, and include the following:

- Plan regular joint meetings (quarterly, semi-annually, etc.) to review up-to-date information on the Comprehensive Special Education Law (Chapter 766), the Act Relative to Early Childhood Intervention Services (Chapter 111G), and other relevant legislation and developments, such as the Early Intervention Operational Standards (DPH). Joint meetings should also identify and address any existing gaps in services.

- Whenever possible, agencies are encouraged to invite staff from other agencies to participate in training.

- Plan for the sharing of responsibilities and resources among sending and receiving agencies and parents on an ongoing basis. Develop and implement a collaborative transition plan which addresses the concerns of children and families.

- Sending programs will provide information annually about children who may need Chapter 766 services to school districts in a way which will ensure the confidentiality of information about families. Early Intervention programs are responsible for making referrals of specific children at least 6 months prior to the child's third birthday.

- A child in an Early Intervention program who is eligible for special education services must have an Individualized Education Plan (IEP) developed by the school district in place, with special education services provided by the school district in accordance with the IEP, commencing on the child's third birthday.

- The Department of Education supports the initiation of the process of transition at two years, six months. To eliminate possible breaks in services for a child transitioning from an Early Intervention program, direct services must begin in accordance with the signed individualized education plan (IEP) no later than a child's third birthday. For planning purposes, sending agencies should contact special education directors to plan the use of community placements well before these programs have reached capacity.

(*) Sending and receiving agencies may include, but are not limited to child care, Early Intervention, Head Start, public/private preschool and kindergarten programs.

Please see:
Appendix A for guidelines to assist agencies in implementing the policy.
Appendix B for steps to follow in interagency planning.

CONCLUSION

As change can be stressful for everyone involved, transition activities should be sensitive to problems that families and children face. They should also facilitate children's ability to participate in new settings, and encourage interagency planning.

The intensified efforts to identify and serve children who have special needs or who are at risk of having special needs mandated under the Individuals with Disabilities Education Act, has generated the need for substantial growth in programs serving young children birth through five. Agencies serving young children will need to expand to accommodate this growth in population. Now, more than ever, the Department of Education, Department of Public Health, Head Start, child care and other agencies need to work together to plan and provide effective services to young children and their families. A carefully planned transition process should benefit children with special needs, their families and agencies, and facilitate the education of children in the least restrictive environment.

APPENDIX A

Guidelines

The following guidelines are included to assist agencies with implementation of the policy.

For children turning three in the spring or summer:

- If the family, the school district and the Early Intervention staff determine at the TEAM Evaluation meeting that it would be appropriate for the child to remain in the Early Intervention program, the TEAM may develop an IEP (or an Individualized Family Service Plan) that specifies the child will continue to receive services provided by the Early intervention program for a limited period of time after the child turns three. The school district will assume the cost of the child's program and services, including transportation and other related services that are included in the IEP in accordance with the Chapter 766 Regulations.

- Because Early Intervention programs are limited in their capacity to provide services to children who have turned three, it is important that the IEP specify: (a) how long the child will remain and what services s/he will receive; (b) the early childhood program in which the child will be placed (i.e., the special education and related services s/he will receive) after leaving the Early Intervention program; and (c) the steps that will be taken to ensure a smooth transition for the child. As required by law, if the child's educational placement is to be changed from that specified in the IEP, the school district must conduct an IEP review.

- Early Intervention programs are responsible for making referrals of specific children, with parental consent, to the child's school district for a special education evaluation at least six months before the child's third birthday. For each child eligible for special education and related services, the school district is responsible to develop and implement an IEP by the child's third birthday. If a child turns three during the summer and the evaluation TEAM has recommended extended school year (summer) services in the IEP, the school district must provide them. Otherwise, the services may be initiated at the beginning of the upcoming school year.

Extended school year services:

- Under state and federal special education law, the Evaluation TEAM may determine that a child should receive special education beyond the regular school year (e.g., during the summer) if it determines that the child will substantially regress without an extended school year program. While federal law requires states and school districts to "ensure a smooth transition" for children from Early Intervention to special education, it mandates summer services only for those children found to need an extended school year program. This means that the three year old may or may not receive services during the summer. The Early Intervention program should prepare the family for this possibility.

Rejection of an IEP:

- School districts are encouraged to conduct the TEAM evaluation for each child referred by an Early Intervention program as soon as possible after the child turns two years and six months old. The parties then have ample time to plan a smooth transition for the child from one program to another, and to resolve any dispute over the IEP before the child turns three.

- The child's parents may reject the IEP proposed by the TEAM or a finding that the child is not in need of special education, and may request mediation or a hearing before the Bureau of Special Education Appeals. While the mediation or hearing process is pending, a child who has turned three and has been found to need special education shall be placed in an appropriate interim program as determined by agreement between the school district and the parents. The school district is responsible for the cost of the child's interim education program. If the school district and the parents do not agree on an interim placement or on whether the child needs special education, either party may request a hearing before the Bureau of Special Education Appeals, which has authority to select an interim placement for the child.

- Nothing precludes the parties or the Bureau of Special Education Appeals from determining that it is appropriate for the child to continue receiving services provided by the Early Intervention program as an interim placement while the dispute over the IEP is being resolved. The school district, not the Department of Public Health, is responsible for the cost of Early Intervention provided to any child over three who is eligible for special education services.

Services provided by a school district for children turning three by December 1:

- Since federal and state regulations require that services to young children with special needs begin on the child's third birthday, school districts are *encouraged* to enroll children turning three by December 1 in early childhood programs at the opening of school in September to minimize disruptions for children, families and staff during the transition process. If a school district has developed an IEP that indicates placement in one of their existing preschool programs for a child turning three years old in the fall, it might be less disruptive for the teacher, child and family to have the child begin the program with her/his classmates when school opens. When making decisions about children starting school before they turn three years old it is important to consider the individual needs and circumstances related to the child and family.

Use of diagnostic evaluation, (Chapter 766 Regulations, paragraph 502.9):

- Diagnostic Evaluation (502.9) may be used for an extended evaluation period when the school district's Evaluation TEAM members believe that the evaluation information is inconclusive and they are unable to develop objectives for the child's IEP. Since young children's development can vary, and diagnostic instruments used for assessing young children can be inadequate and often reveal inconclusive information, it would be appropriate to use a diagnostic evaluation concurrently while completing further assessments. When using a Diagnostic Plan, the evaluation TEAM should follow the procedures described in Chapter 766 Regulations, paragraph (502.9), and specify the questions they are attempting to answer.

- When transitioning young children with special needs from one program to another, a Diagnostic Evaluation (502.9) should be used only when the TEAM determines that there is a need for more information (diagnostic/observational purposes) and not as a general practice.

Transition of children turning three and time lines to follow:

- The child must have an **IEP implemented on the third birthday regardless of when the referral was received.** Therefore, it is essential that **Early Intervention programs make referrals early** to give school districts ample time to plan and act on the referral received.

- On or about the time of the child's second birthday, the Early Intervention program, with parental consent, shall notify the child's school district of the child's identity and the nature of the program s/he is receiving. At or about the time the child reaches age two years six months, the Early Intervention program, with parental consent, shall refer the child to the school district for evaluation.

- To ensure a smooth and timely transition, it is essential for Early Intervention programs and school districts to begin the referral process early to ensure determination of eligibility for special education services and that the necessary time lines are followed in respect to Chapter 766 Regulations, paragraphs 319 (45 school working days to evaluate the child and develop the IEP) and 325.1 (30 days for the parent to sign the IEP and exercise options).

- The school district's obligations to provide special education to the child begins on the child's third birthday. Therefore if an IEP is completed a few months earlier than a child's third birthday and signed by the parent, the school district *may* begin to provide services immediately, but it is not required to provide services until the day of the child's third birthday.

- If a child turns three during the summer and the evaluation TEAM has recommended extended school year (summer) services in the IEP, the school district must provide them. Otherwise, the services may be initiated at the beginning of the upcoming school year.

APPENDIX B

STEPS TO FOLLOW IN INTERAGENCY PLANNING

Transition planning, which includes both a child's family and sending and receiving agency staff, will:

- Identify tasks necessary to implement transition of the child, agree on who will perform them, and establish time lines.

- Establish procedures and time lines for formal referral of the child to the local school system for initiation of Chapter 766 process.

- Plan for transfer of records and any additional assessments, avoiding unnecessary or duplicative evaluations.

- Agree on pre-placement activities that facilitate direct contact between the child, the parent and the receiving teacher, and that support parents in planning for adjustment to the new setting.

- Pre-placement activities should include:
  - parent visits to possible program options
  - information sharing between teachers in sending and receiving agencies
  - arrangement for parent training (planned jointly by involved agencies)
  - consultations between sending teacher/case manager and family and receiving teacher

- Plan for follow-up activities. Evaluations of the process should be planned and carried out between the family and the agencies involved.

<u>Implementation of the Transition Process</u>
Activities formulated in the planning process [e.g., formal information-sharing meetings(s); formal referral to the local school system; scheduled pre-placement activities, and follow-up] will be initiated and carried out through the collaborative and cooperative efforts of the families and agencies involved.

INTERAGENCY AGREEMENT BETWEEN THE OFFICE OF CHILD CARE SERVICES AND THE DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF PURPOSE

The Office of Child Care Services (OCCS) is mandated to license and regulate child care programs throughout the Commonwealth and to promote the development of programs and services to all children emphasizing programs for children with special needs. G.L. c. 28A, § 4.

The Massachusetts Department of Public Health (DPH) has statutory responsibility for the establishment of a statewide Early Intervention (EI) system and the responsibility for monitoring the effectiveness of this system.

Because OCCS and DPH are mandated to ensure that the children of the Commonwealth have access to services that support the needs of all children, including those with disabilities, OCCS and DPH undertake the following mutual commitment toward maximizing the availability of early intervention services and developmentally sound child care in OCCS licensed facilities.

1. DPH agrees that center-based child group component of EI programs are subject to OCCS licensure and regulations. DPH further agrees that OCCS regulations shall govern the supervision of the center-based child group component; the health and safety standards for the facility, furnishings and equipment; policies addressing the care of children; and the implementation of the early childhood education curriculum.

OCCS agrees to develop licensing guidelines that support DPH contract and operational standards for the effective delivery of early intervention services. OCCS further agrees that DPH contract and operational standards shall govern the administration and delivery of all EI services; development of Individualized Family Service Plans; and Recordkeeping functions.

OCCS and DPH agree, as appropriate, to use variances and waivers as alternative methods of achieving program compliance.

2. OCCS and DPH agree that the administration of the center-based component of all OCCS licensed EI programs shall include a person who is qualified as both a "Lead Teacher" under 102 CMR 7.21(c)(2) and as an "Educator" under Section V of the EI Standards. An administrator who is Director I or Director II qualified under 102 CMR 7.21 may be required as determined by the component's licensed capacity.

3. OCCS and DPH agree, to the extent permitted by law, to share projected visit schedules; conduct joint visits for the purpose of licensing studies and contract monitoring; exchange visit reports, investigation reports, other complaint or investigation materials or other information and make trainings available to agency staff.

4. DPH agrees to provide OCCS with a list of the locations of all contracted EI programs, including satellite sites.

OCCS agrees to provide DPH with a list of all licensed EI facilities.

5. DPH agrees to verify with OCCS that a program has been either licensed or exempted before initiating a contract for a new EI program.

6. OCCS agrees to notify DPH of any corrective or legal action taken against an EI program and its resolution. OCCS further agrees to provide a copy of the legal document(s) to DPH.

DPH agrees to notify OCCS of any comparable action taken against a licensed EI program for failure to comply with its operational standards. DPH further agrees to provide OCCS with documentation relating to the action.

This Agreement may be amended or terminated, with or without cause, by thirty (30) days' written notice by either party.

DEPARTMENT OF PUBLIC HEALTH

Howard K. Koh MD MPH
By: Howard Koh
Commissioner
11/22/99

OFFICE OF CHILD CARE SERVICES

Ardith Wieworka 10/19/99
By: Ardith Wieworka
Commissioner

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

EARLY INTERVENTION OPERATIONAL STANDARDS

APPENDIX B:

PROCEDURAL SAFEGUARDS and DUE PROCESS PROCEDURES

MASSACHUSETTS EARLY INTERVENTION SYSTEM
PROCEDURAL SAFEGUARDS and DUE PROCESS STANDARDS

Purpose

The purpose of these standards is to establish due process standards for public and private early intervention programs certified or funded by the Department of Public Health with respect to notice of rights, informed consent, records and confidentiality, appeals and complaints.

A. The Massachusetts Department of Public Health shall be responsible for:

1. Establishing or adopting due process procedures that meet the requirements of 34 CFR 303.400 through 303.406, 303.419 through 303.425, 303.460 and 303.510 through 303.512 and providing parents a means of filing a complaint or requesting to resolve a disagreement through mediation.

2. Ensuring effective implementation of the safeguards by each provider in the Commonwealth that is involved in the provision of early intervention services under this part.

3. Ensuring that an impartial person will be appointed to implement the complaint resolution process referred to in this section.
   a. "Impartial" as used in this section means that the person appointed:
      i. is not an employee of any agency or other entity involved in the provision of early intervention services or care of the child; and
      ii. does not have a personal or professional interest that would conflict with his or her objectivity in implementing the process.

4. Establishing or adopting policies and procedures to ensure the protection of any personally identifiable information collected, used, or maintained under this part, including the right of parents to written notice of and written consent to the exchange of this information across agencies or providers consistent with Federal and State law.

5. Ensuring that, parents of a child eligible under Part C are given notice that they may determine whether they, their child, or other family members will accept or decline any early intervention service under this Part in accordance with these due process procedures and may decline such a service after first accepting it, without jeopardizing other agreed upon early intervention services under this part.

B. These policies and procedures are intended to meet the requirements as stated in 34 CFR 300.560 through 300.576 (Part B) with the modifications specified in 34 CFR 303.5(b).

II.) Authority

These procedures are adopted pursuant to 34 CFR 303.400 - 303.406, 303.419 through 303.425, and 303.510 - 303.512

III.) Scope

These procedures govern the conduct of early intervention providers and the Department with respect to certain aspects of evaluation, assessment, eligibility for services, and the provision of early intervention services. The regulations are based upon the Department's participation in the federal Part C program.

IV.) Definitions

A. *Days* shall mean calendar days.

B. *Early intervention services* shall mean those services specified in 34 CFR 303.12, 303.13 and 303.14.

C. *Parental consent* shall mean that:

1. The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language unless clearly not feasible to do so, and shall otherwise be done in the manner best understood by the parent.

2. The parent understands and agrees in writing to the carrying out of the activity for which consent is sought ,and the consent describes that activity and lists the records (if any) that will be released and to whom; and

3. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

The explanation shall be in the parent's native language unless clearly not feasible to do so and shall otherwise be done in the manner best understood by the parent. The parent shall have an opportunity to discuss the explanation and to have questions answered. If the explanation is not in the parent's native language, the parent shall be provided, whenever feasible, with a list of interpreters in that language.

D. *Native language* shall mean the language or mode of communication normally used by the parent of a child seeking or using services. If the parent has a vision or hearing impairment, the mode of communication shall be that normally used by the parent, such as sign language, Braille, oral communication or other appropriate mode of communication.

E. *Parent* shall mean;

1. a natural or adoptive parent of the child,

2. a guardian,

3. a person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives),

4. a person who is legally responsible for the child's welfare; or a surrogate parent who has been assigned in accordance with 34 CFR 303.406 (section VI (C). of these standards)

5. a foster parent may make decisions required of a parent under Part C of the Act if:
   a. The natural parents' authority to make decisions required of parents under the Act has been terminated under State law; and
   b. The foster parent –
      i. has an ongoing, long term parental relationship with the child;
      ii. is willing to make decisions required of parents under the requirements of these Due Process procedures; and
      iii. has no interest that would conflict with the interests of the child.

F. *Personally identifiable* shall mean information that includes:

1. the name of the child, the child's parent, or other family member,

2. the address of the child,

3. a personal identifier, such as the child's or parent's social security number; or

4. a list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty.

G. ***Early Intervention provider*** shall mean any public or private program which offers early intervention services and which is funded or certified by the Department to provide such services.

H. ***Written informed consent*** shall mean a form or other written record which serves as evidence that the explanation required for informed consent, as defined in subsection C of this section, has been provided. The parent's signature shall serve as documentation that the parent understands and agrees to the proposed terms and activities.

I. ***Destruction*** shall mean the physical destruction or removal of personally identifiable information from all records.

J. ***Education record*** means the record covered by the Family Educational Rights and Privacy Act (FERPA:34 CFR Part 99)

K. ***Participating agency*** shall mean any agency, provider or institution, which collects, maintains or uses personally identifiable information or from which such information is obtained.

V.) Notice of Rights

A. Upon receipt of a referral or application, and upon initial development and periodic review of the Individualized Family Service Plan (IFSP), the parent shall be given a notice in writing of the process involved in arranging for and providing assessments, evaluations, and services and the rights of the parent in that process. The notice shall be written in language understandable to the general public.

1. The notice shall be in the parent's native language, unless clearly not feasible, or otherwise in the manner best understood by the parent.
   a. If the parent's native language or other mode of communication is not written, the program shall ensure that the notice is translated orally or by another means in the parent's native language unless clearly not feasible to do so and shall otherwise be done in a manner best understood by the parent;
   b. If the parent is deaf or blind, or has no written language or mode of communication, the notice shall be provided in the language/mode of communication normally used by the parent unless clearly not feasible to do so and shall otherwise be done in a manner best understood by the parent.

2. The provider will ensure that:
   a. the parent understands the notice to the maximum extent feasible;
   b. there is written evidence that these requirements have been met;
   c. the parent has been given an opportunity to discuss the contents of the notice and have questions answered.

3. The notice shall specify the right to:
   a. receive a multidisciplinary eligibility evaluation of a child from 0 through 2 years of age within 45 days of referral;
   b. if eligible, receive appropriate assessment and IFSP development within 45 days of referral;
   c. if eligible, receive appropriate services for the child and family;

d. receive notice of the opportunity to participate in any meeting where it is expected that a decision will be made about early intervention services for a child or family;
e. receive notice before a provider proposes or refuses to initiate or change an identification, placement, evaluation, assessment or service, in accordance with this section;
f. grant or refuse informed consent in accordance with section VI (A)&(B);
g. appeal a disputed matter concerning an evaluation, identification, placement, assessment or the process of IFSP development (in accordance with the section on Complaint Resolution), section IX;
h. file a complaint about non-compliance issues or any violation of Part C (34 CFR 303.1-303.654) in accordance with Section VIII.
i. confidentiality of personally identifiable information, in accordance with the definition of personally identifiable section VII;
j. review, or amend records, in accordance with section VII;
k. use a lawyer, advocate or other representative in any matter pertaining to early intervention services;
l. receive an explanation of the use of and effect upon insurance;
m. appeal a decision of a hearing officer to an appropriate state or federal court;
n. other appropriate procedural safeguards available under Part C (CFR 303.400-303.460 and 303.510-303.512

B. The parent shall be given a readily understandable written notice a reasonable time before a provider proposes or refuses to initiate or change the identification, evaluation or placement of a child, or the provision of early intervention services to the child or family.

1. The notice shall be in the parent's native language, unless clearly not feasible, or otherwise in the manner best understood by the parent.

a. If the parent's native language or other mode of communication is not written, the program shall ensure that the notice is translated orally or by another means in the parent's native language, unless clearly not feasible to do so, or otherwise in a manner best understood by the parent;
b. If the parent is deaf or blind, or has no written language or mode of communication, the notice shall be provided in the language/mode of communication normally used by the parent, unless clearly not feasible to do so or otherwise in a manner best understood by the parent.

2. The provider will ensure that:

a. the parent understands the notice to the maximum extent feasible; and
b. there is written evidence that these requirements have been met.
c. the parent shall be given an opportunity to discuss the contents of the notice and have questions answered.

3. The notice shall specify:

a. the action(s) being proposed or refused and what will happen with respect to actions which the parent objects to or requests;
b. the reasons for taking the action(s); the need for informed consent, as specified in section VI (A)&(B), and the right to refuse consent;
c. when applicable under section VIII, the right to request a mediation or due process hearing or file a complaint, and to receive services not in dispute:
d. the right to consent to some services, evaluations, and assessments and reject others, without jeopardizing other services under this part;
e. all other procedural safeguards available under Part C (CFR 303.401-303.460).

VI.) Parent Consent

A. Written parental consent, as defined in section IV (C), must be obtained:

1. before conducting an evaluation or assessment or a reassessment or re-evaluation. Prior to any assessment involving family members, informed consent satisfying the requirement of IV (C) shall be obtained from all involved family members;

2. at the time the initial IFSP and any subsequent IFSP is developed or any revisions are made to an IFSP;

3. before a change in identification, placement, evaluation, assessment, or reduction in services or change in the type of services.

B. If a parent does not give consent, the program must make an effort to ensure:

1. that the parent is fully aware of the nature of the evaluation, assessment or services that would be available; and

2. that the parent understands the child will not be able to receive an evaluation, assessment or services without consent.

C. Parent's Right to Decline Service

Parents may determine whether they, their child or other family members will accept or decline any early intervention service. Parents may also decline such a service after first accepting it, without jeopardizing other early intervention services.

D. Surrogates

1. The provider should, within a reasonable time of application or referral, assign a surrogate to represent the rights of eligible children in the following circumstances:

   a. when the provider, after reasonable efforts, is unable to identify or locate the parent, guardian or person acting as parent of a child (this includes a foster parent as specified in Sec IV (E, 5) unless he or she indicates or demonstrates an unwillingness or inability to serve in this capacity);

   b. when the child is in the legal custody of a state agency.

      i. If the foster parent is unwilling or unable to serve as "parent" for the child, the provider, with the assistance of the IFSP team, should endeavor to appoint an effective advocate for the child, with preference given to someone who is known to the child and family and has an understanding of the child and family's cultural, linguistic and religious background.

      ii. The provider will ensure that the person selected as a surrogate parent has knowledge and skills that ensure adequate representation of the child; and that the surrogate is impartial, has no interest which conflicts with the child's interests and is not an employee of the provider or any other agency providing early intervention services to the child or to any family member of the child, the Departments of Public Health or Social Service, or any other state agency involved in the provision of services to the child.

      iii. Even when there is a surrogate appointed, if reunification of the child and the natural parent is the goal of the DSS service plan, the provider shall make every effort to have the natural parent participate in decision making about the provision of services, unless the natural parent's rights to participate have been terminated by judicial process.

2. The surrogate shall have the same rights as a parent under these standards, including the right to consent, revoke or withhold consent and to represent the child in all matters pertaining to evaluation, assessment, IFSP development, the provision of early intervention

services and any other rights established under this part.

3. In the event that the provider is unable to identify a suitable surrogate for a child in state custody, the Department shall appoint a surrogate. The Department shall maintain a list of approved surrogates and procedures for appointing a surrogate from that list.

   a. The Department shall endeavor to appoint an effective advocate, with a preference given to a person with an understanding of the child and family's cultural, religious and linguistic background.

   b. The Department shall ensure that the person selected as a surrogate parent has knowledge and skills that ensure adequate representation of the child; he/she will be knowledgeable and trained in the developmental needs, service options, and legal rights of children eligible for early intervention services, shall be impartial, have no interest which conflicts with the child's interests and shall not be an employee of the Department, the Department of Social Services or a provider; provided, however, that such person may be paid by the Department for serving as a surrogate.

VII.) Records

A. Definition

1. A ***record*** is any information, regardless of location, recorded in any way, maintained by an agency or service provider or any party acting on behalf of the agency or service provider.

2. A ***record*** includes any file, evaluation, report, study, letter, telegram, minutes of meetings, memorandum, summary, intra-office communications concerning an individual, notes, charts, graphs, data sheets, films, videotapes, slides, sound recordings, discs, tapes and information stores in microfilm or microfiche or in computer readable form.

B. Parent Access

1. The Department of Public Health and the provider shall presume that the parent has the authority to review and inspect records related to the child unless the Department or provider has been advised that the parent does not have this authority under state law.

2. The Department or provider shall, within five days of request, give the parent a list of the types and locations of records collected, maintained or used by the Department or provider.

3. The parent shall be afforded the opportunity to inspect and review any such record relating to evaluations, assessments, eligibility determination, development and implementation of IFSP, due process hearing, individual complaints dealing with the child, and any other area involving records about the child/family. This includes all records collected and maintained by the provider. The provider should notify all parties asked to submit records for a child's file that they are open to the parent under the provisions of 34 CFR 303.402 and 34 CFR 300.560 through 300.576.

4. The right to review a record includes the right to an explanation or interpretation of the record and the right to have a representative of the parent view the record and the right to request that the agency provide a copy of the records containing the information. Agencies may charge a reasonable fee for copying records, if the fee does not prevent the parent from exercising the right to inspect and review records. Agencies may not charge fees to search for or retrieve records.

5. An agency or service provider shall comply without unnecessary delay and no later than 10 days of receiving the request.

6. Where records are requested in connection with a meeting regarding the IFSP or a formal hearing, the agency or service provider shall comply at least five days before the meeting or hearing.

7. If a record contains information on more than one child, the parent has a right to inspect only those portions of the record pertaining to his or her child.

C. Amending the Record

1. If a parent feels that the information in early intervention records that is collected, maintained, or used is inaccurate, irrelevant, misleading, or violates the privacy or other rights of the child, he/she may request that the participating agency which maintains the records to amend the information.

2. The holder of the record shall respond within 30 days. If the holder of the record finds that the objection is valid, it shall amend the contents of the records or the methods for holding or using such data and duly notify the parent in writing. If the holder refuses to amend the record, it shall so notify the parent in writing of the decision, the right to appeal pursuant to section VIII, and the right to place a statement in the record reflecting the parent's views, which would be maintained and disseminated with the rest of the record.

3. In responding to a parent's objection, the holder of the record may not amend the contents of a record that was submitted to the child's file by a source outside of the provider agency. The provider may agree to amend the record by placing a statement in the record reflecting the parent's (and/or the provider's) views and direct the parent to contact the originator of the record to request that a corrected copy be placed in the file.

4. A parent, upon request, must be granted a hearing to challenge information contained in an early intervention educational record.

   a. such a hearing shall be conducted under procedures in section 99.22 of the Family Educational Rights and Privacy Act (FERPA: 34 CFR Part 99);
   b. If the hearing officer finds that the information is inaccurate, misleading, irrelevant, or violates the privacy or other rights of the child or family, the record shall be amended and the parent so notified in writing.
   c. If the hearing officer finds that the information is not inaccurate, misleading, irrelevant, or not a violation of the privacy or other rights of the child and family, the parent shall be informed of the right to place in the record a statement of the parent's views. This statement shall be maintained by the agency for as long as the contested part of the record is maintained, and disseminated with the record.

D. Confidentiality

1. The Department of Public Health and providers shall ensure the protection of confidential personally identifiable information at collection, storage, disclosure and destruction stages.

2. All records and information pertaining to a child or family shall be confidential. All holders of personally identifying information shall comply with the confidentiality provisions of M.G.L. c. 66A and related regulations. All records must contain an access sheet that keeps record of parties obtaining access to the record. This sheet must list the name of the party requesting access, and the date and purpose of access.

   a. Records and personally identifying information shall not be disclosed, even to prospective providers of services, without the parent's written informed consent; provided, however, that records may be inspected by health personnel in response to a health or safety emergency or by state and federal agencies for purposes of audit, evaluation for compliance with legal and contractual requirements, and certification. Personally identifiable information shall not be

used for purposes other than meeting the requirements of this part without parental consent. Beyond these exceptions any additional release of information will not occur without parental consent.

b. The Department and each provider shall appoint an employee responsible for ensuring confidentiality. The Department and each provider shall maintain a current list of employees with access to personally identifiable information and shall provide these employees with training concerning the state's policies and procedures under 34 CFR 300.129 and 34 CFR Part 99 (FERPA). Supervision and monitoring procedures will ensure that all providers meet confidentiality requirements.

3. A record holder shall establish written procedures which protect the contents of early intervention records containing sensitive information, such as information pertaining to sexual or physical abuse, mental health treatment, HIV or other communicable disease status, or a child's parentage.

4. If the Department or provider maintains personally identifying early intervention information not subject to the Family Educational Rights and Privacy Act (FERPA: 34 CFR Part 99), it shall protect that information pursuant to the confidentiality provisions of 5 USC 522A and related regulations.

5. Upon discharge from early intervention services, the provider shall notify the parent that personally identifiable information is no longer needed to provide services to the child or family. Such information must be destroyed at the request of the parent, or the provider may destroy it after seven years. However, a permanent record may be maintained without time limitation of the child and family's name, address and phone number, and the types and dates of services received.

6. The Department and program shall meet any additional confidentiality requirement specified in 34 CFR 300.560 - 300.576 with the following modifications:

a. any reference to the "State Education Agency" means the Department of Public Health;
b. any reference to "special education", "related services", "free appropriate public education", "free public education" or "education" means the provision of early intervention services;
c. any reference to "local education agencies" and "intermediate educational units" means certified early intervention programs;
d. any reference to "Identification, Location and Evaluation of the Child with Disabilities" means "Comprehensive Child Find System."
e. any reference to "Confidentiality of Personally Identifying Information" means "Confidentiality of Information";
f. any reference to "education records" means the type of records covered under the definition of education records in Part 99 of the Family Educational Rights and Privacy Act of 1974 (FERPA);
g. any reference to "participating agency" when used in reference to a local educational agency or an intermediate educational agency, means a local service provider;
h. any reference to "destruction" means physical destruction or removal of personal identification from information.

VIII.) Lead Agency Procedures for Complaint Resolution

The Department of Public Health offers parents of children enrolled in Massachusetts early intervention programs and others, options for the resolution of complaints and/or disputes. The following procedural

safeguards reflect the federal regulations of Part C of IDEA (34 CFR 303.419-303.425 and 303.510-512) and provide parents a means of filing a complaint or requesting to resolve a disagreement through due process in a timely, impartial and consistent manner.

1. In accordance with 34 CFR Sec. 303.510 – 303.512, the Massachusetts Department of Public Health shall be responsible for adopting written procedures to (1) investigate any complaint that it receives (including individual child complaints and those that are systemic in nature) and (2) resolve the complaint if the agency determines that a violation has occurred. This includes a complaint filed by an organization or individual from another State indicating that any public agency or private service provider is violating a requirement of the regulations as stipulated by Part C of the Individuals with Disabilities Education Act (IDEA).

2. All such complaints and requests for mediation and/or due process hearings shall be filed with the Department.

3. Information on the availability of this type of administrative complaint resolution process shall be widely disseminated to parents and other interested individuals, including parent training centers, protection and advocacy agencies, independent living centers and other appropriate entities, the States procedures under Sections 34 CFR 303.510 through 303.512.

A. Formal Administrative Complaints

1. In resolving a complaint in which it finds failure to provide appropriate services, the Department will address:

   a. How to remediate the denial of those services, including, as appropriate, the awarding of monetary reimbursement or other corrective action appropriate to the needs of the child and the child's family; and
   b. Appropriate future provision of services for all infants and toddlers with disabilities and their families.

2. In accordance with CFR Sec. 303.511, an individual or organization may file a written, signed complaint under Sec. 303.510. The complaint must include:

   a. A statement that the State or early intervention provider has violated a requirement of Part C of the IDEA or the regulations in this part; and the facts on which the complaint is based.
   b. Limitations. The alleged violation must have occurred not more than one year before the date that the complaint is received by the Department unless a longer period is reasonable because:
      i. the alleged violation continues for that child or other children; or
      ii. the complainant is requesting reimbursement or corrective action for a violation that occurred not more than three years before the date on which the complaint is received by the public agency.

3. In accordance with 34 CFR Sec. 303.512:

   a. The Department shall include in its complaint procedures a time limit of 60 calendar days after a complaint is filed under Sec. 303.510(a) to:
      i. carry out an independent on-site investigation, if the Department determines that such an investigation is necessary;
      ii. give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

iii. review all relevant information and make an independent determination as to whether there has been a violation of a requirement of Part C of IDEA or of this Part; and

iv. issue a written decision to the complainant that addresses each allegation in the complaint and contains findings of fact, conclusions and the reason for the lead agency's final decision. The Department's procedures may permit an extension of the time limit under paragraph (a) of this section only if exceptional circumstances exist with respect to a particular complaint.

v. include procedures for effective implementation of the Department's final decision, if needed, including—

- technical assistance activities;
- negotiations; and
- corrective actions to achieve compliance.

4. If a written complaint is received that is also the subject of a due process hearing under Sec. 303.420, or contains multiple issues, of which one or more are part of that hearing, the Department will set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action will be resolved within the 60-calendar-day timeline using the complaint procedures described in paragraphs (3) (a) and (b) of this section.

5. If an issue is raised in a complaint filed under this section that has previously been decided in a due process hearing involving the same parties—

a. The hearing decision is binding; and
b. The Department must inform the complainant to that effect.

6. The Department will resolve a complaint alleging a public agency's or private service provider's failure to implement a due process decision.

IX.) Requests for Due Process Hearings and Mediations

A. Filing:

1. A parent or early intervention provider may file a request for a due process hearing and/or mediation under this subsection on any issue in dispute as to identification, evaluation, assessment, determination of eligibility, the process of developing the IFSP, and the appropriateness of early intervention services to be provided. A parent or provider may also seek resolution of a dispute by filing a complaint pursuant to section VIII.

a. A request for a due process hearing or mediation shall be in writing. As needed or requested, the Department shall assist the parent in drafting and filing the hearing or mediation request.

b. Within three days of receiving a request for a due process hearing or mediation under this subsection (A), the Department shall notify the parent of free or low cost legal and advocacy services, and of the right to be advised by an individual with special knowledge of early intervention services; the option of mediation, including a description of the mediation process and its voluntary nature; and the alternative of having the Department investigate the complaint pursuant to 34 CFR 303.510 through 303.512. The Department shall also send the parent a copy of the notice of rights specified in this section.

c. During the pending process of appeal or mediation, the child and family shall be entitled to those services which are currently being provided or, if initial services, are not in dispute. If there is a dispute between agencies or providers as to payment for early intervention services provided under the IFSP, the Department shall ensure the provision of services without charge until the dispute is resolved.

B. Mediation Process:

1. Whenever a hearing is requested, parties must be offered the choice to resolve their disputes through a mediation process. Mediation may also be offered and accessed at any time to resolve a dispute. If mediation is requested, the Department shall promptly appoint a qualified and impartial mediator who is trained in effective mediation techniques. The mediator shall promptly schedule a meeting to be held within 14 days, unless otherwise requested by the parent, at a mutually convenient time and place.

2. The Department will send the parent(s) a list of free of low-cost attorneys and advocates who may be available to assist parents through the process.

3. The Department will ensure that the mediation process is:

   a. voluntary on the part of the parties;
   b. is not used to deny or delay a parent's right to a due process hearing or any other rights afforded under 34 CFR Sec. 303.400 – 303.460 and 303.510-303.512;
   c. is conducted by a qualified and impartial mediator.

4. The Department shall maintain a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of special education and related services.

5. The Department shall bear the cost of the mediation process.

6. Each session in the mediation process must be scheduled in a timely manner and must be held in a location that is convenient to the parties.

7. A parent may proceed with the hearing process while engaged in mediation. A parent may also request mediation at any time in the hearing process.

8. An agreement reached by the parties to the dispute in the mediation process must be set forth in a written mediation agreement.

9. Discussion that occurs during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearing or civil proceedings, and the parties to the mediation process may be required to sign a confidentiality pledge prior to the commencement of the process.

C. Procedures to Address the Requests for Due Process Hearing

1. Upon receipt of a request for due process hearing under this section, the Department shall promptly appoint an impartial hearing officer who shall be knowledgeable about the provisions of Part C and the needs of and services available to eligible children. Such hearing officer shall be impartial, and shall not have a personal or professional conflict of interest that interferes with objectivity. The hearing officer shall not be an employee of the Department, or an agency or provider involved in the provision of early intervention services to, or care of the child; provided, however, that such person may be paid by the Department to serve in the capacity of hearing officer.

2. If a parent initiates a request for a due process hearing, the Department will inform the parent of the availability of mediation described in section IX B (34 CFR 303.419).

3. The Department will send the parent(s) a list of free of low-cost attorneys and advocates who may be available to assist parents through the process.

4. The hearing officer shall: promptly arrange for a hearing at a time and a place that is reasonably convenient to the parents and duly notify the parties; listen to the presentation of the relevant viewpoints about the issue(s) in dispute; examine all information relevant to the issues; seek to reach a timely resolution of the complaint; provide a record of the proceedings and mail a written decision to each of the parties.

5. The pre-trial and hearing process shall be governed by the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.00, and shall include the right to present evidence, and confront, cross-examine and compel the attendance of witnesses. In addition, the parent shall have the right to:

   a. have the child and family be accompanied and advised by their own legal counsel and by other individuals with special knowledge or training with respect to early intervention services;
   b. have the hearing closed to the public, unless otherwise requested by the parents;
   c. prohibit the introduction of evidence not disclosed at least five days prior to the proceeding, unless agreed to by the parties;
   d. have the child, who is the subject of the hearing, present;
   e. be provided with an interpreter whenever feasible at no charge, if required for proper adjudication of the matter;
   f. be provided with an electronic, or if unavailable, a written verbatim transcription of the proceeding;
   g. obtain written findings of fact and a written decision.

6. A decision shall be rendered within 30 days of receipt of the request for a hearing.

7. Not later than 30 days after the receipt of a parent's complaint, the parties shall be notified by mail in writing of the decision, the reasons for the decision, all relevant findings of fact and conclusions of law, and the right to appeal the decision in state or federal court.

8. The Department will maintain a central file of decisions, which shall be a public record with the exception of personally identifying information.

9. The hearing officer's decision shall be promptly implemented.

D. Status of Child During Proceedings

1. During the pendency of any administrative or judicial proceeding involving a request for a due process hearing under section IX.B. and C. (CFR 303.420), unless the public agency and parents of a child otherwise agree, the child must continue to receive the appropriate early intervention services currently being provided.

2. If the proceeding involves an application for initial services under this section, the child must receive the agreed upon service.

3. This section does not apply if a child is transitioning from early intervention services under this part to preschool services under Part B of the IDEA.